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ABSTRACT

This publication reports on an evaluation commissioned by the Greater Glasgow (Scotland) Health Board of a school sexual health education program. The program emphasized providing accurate and relevant sexual health information; promoting pupils' ownership of their own sexual health issues; developing pupils' informed decision-making abilities concerning sexual activity; and encouraging peer support within classes. The findings of the 1993 evaluation revealed that while the model had taken time and resources, this approach had led to a curriculum that met the sexual health needs of the majority of pupils in the target school, developed and enhanced teachers' skills, and promoted teachers' confidence in providing sexual health education. Overall themes emerging from the evaluations are summarized in five broad categories: (1) pupils' satisfaction with the program; (2) communication issues between teachers and pupils; (3) factors affecting learning and pupil involvement; (4) the role of external providers of sexual health education; and (5) the challenge for collaborative sexual health programs. Summaries of the three phases of the sexual health program and corresponding evaluation and findings are included in the appendices. Contains nine references. (ND)

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An Evolving Sexual Health Education Programme

From Health Workers to Teachers

Kevin Lowden
Janet Powney

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An Evolving Sexual Health Education Programme

From Health Workers to Teachers

Kevin Lowden
Janet Powney

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Executive Summary

Evaluating a school-based sexual health programme

In the period September 1993 to August 1996 the Scottish Council for Research in Education (SCRE) was commissioned by The Greater Glasgow Health Board to evaluate a pilot sexual health programme. This programme was part of a wider sexual health model the Health Board was designing for schools. The secondary school where the programme was evaluated has about 660 pupils and is located in an area recognised as an area of multiple disadvantage and is designated by the regional authority as an Area for Priority Treatment. This area of Glasgow also has a relatively high level of teenage sexual activity and pregnancies. Each year the programme has evolved in the light of experience and the evaluation findings but continues to work towards the overall aims of the total initiative. These aims and ethos of the overall model emphasise:

- Providing accurate and relevant sexual health information
- Promote pupils' ownership of their own sexual health issues
- Developing pupils' informed decision-making abilities concerning sexual activity
- Encouraging peer support within classes.

Greater Glasgow Health Board's sexual health model

The findings of the evaluations conducted since 1993 reveal that the overall model or approach developed by the Greater Glasgow Health Board has taken time and resources but these appear to have been a good investment in the production of a sustainable and relevant school-based sexual health programme. In particular, this pilot approach has:

- led to a curriculum which meets the sexual health needs of the majority of pupils in the target school. However, some older pupils (mainly S5), still feel reticent about discussing sexual health issues with the teachers.
- developed and enhanced teachers' skills and promoted their confidence in providing sexual health education.

Overall themes emerging from the evaluations

Pupils' satisfaction with the programme

- The pupils greatly appreciate the existence of a sexual health programme which, they claim, generally provides them with core information, provides opportunities to discuss their concerns, helps to develop useful skills to assist them make informed decisions and improve their relationships.
- Despite the reservations some S5 pupils have about discussing some subjects with teachers, they and the majority of other pupils, still feel that the school provides the most accurate and useful sexual health information and advice compared to other sources such as friends and parents.

Communication issues between teachers and pupils

- Communication between teachers and older pupils on sexual health can be inhibited when pupils perceive teachers will have to take a judgmental stance, or compromise their confidentiality. Teachers and pupils can also believe the other is too embarrassed to raise and discuss important topics.
- The training for teachers who provide sexual health education involves developing skills to promote rapport and discussion and builds on their existing skills as PSE teachers. This is important to the quality of teaching. However, teachers will have continually monitor and work on this issue to promote communication and understanding between themselves and pupils
- The provision of factual information in school-based sexual health education, such as bodily changes or the way STDs are transmitted, is perhaps more easily undertaken compared to those topics which more explicitly involve values and relationship issues.
- Pupils often have a limited awareness of the rationale underlying the approaches teachers adopt and why certain topics can be problematic from a teacher's point of view. Unless the teachers' position is made clear, pupils can believe their concerns are being ignored and avoided. This can create a barrier to learning rapport. Such a barrier to communication can mean teachers are sometimes unaware of the strength of feeling underlying the sexual health needs and concerns of certain groups of pupils.

Factors affecting learning and pupil involvement

- Pupils seem to be willing to engage more fully in the learning experience if their teacher: treats them as responsible young people with their own opinions; respects their point of view but is willing to challenge them; responds to their questions and is not evasive; demonstrates competence in the subject matter and upholds confidentiality.
- Pupils have a tremendous thirst for information concerning sexual health. Even when a teacher is able to respond to their questions, the time available for lessons can often limit the amount of discussion of points raised in class. Therefore, other sources of easily accessible information (ranging from posters, leaflets and external health promotion services) which are high profile can help pupils find out more about topics of interest or concern to them.
- It is clear from the evaluation of this pilot school's sexual health programme that a spiral curriculum (where similar topics are revisited in the expectation of pupils having moved on) is particularly well suited to meet the range of developing needs of pupils.

The role of external providers of sexual health education

- Support from external specialists can work well especially when teachers feel they have reached the boundaries of what they can provide but some pupils' needs remain to be met. However, this input is often limited because of resource constraints. Teachers suggest that limited and targeted teaching by health board workers can be an extremely useful option.

The challenge for collaborative sexual health programmes

- Overall, the Greater Glasgow Health Board model for a sexual health programme has demonstrated a fruitful collaboration between education and health board services. The effort this required by all the participants should not be underestimated. There are different professional traditions, planning timescales, expertise and levels of confidence about the subject matter and about working in classrooms. The teams working on this initiative were willing to negotiate and periodically renegotiate in the light of experience. Health workers supported teachers with a training programme and teachers had the courage to tackle new topics. The remaining challenge is for such programmes to continue to develop and be sustained over time. In particular, personnel changes and curricular pressures are factors which could effect the sustainability of effective programmes.
- Promoting and maintaining communication between teachers, the Health Board and the pupils at all stages of the process will help ensure the programme remains relevant and is provided in an appropriate way.
- While sexual health programmes can play an important role in promoting health they are only one contributor to the sexual health of young people. The social and cultural environment of individuals and groups and the influence of peers, family and the media all play a part in shaping the behaviour and attitudes of young people. Therefore, it is necessary to have realistic expectations of school-based sexual health programmes.

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1 Sexual health education: approaches, impact and evaluation

Research has shown that young people are becoming sexually experienced at a younger age (Johnson *et al* 1994). Some commentators (eg Whelan 1995) argue that sexual health education has actually helped promote earlier sexual activity. However, Wellings *et al* (1995) and Mellanby *et al* (1995) have shown that, rather than promote early sexual activity, sexual health programmes can delay sexual activity among young people.

Such evidence and a growing political commitment to address the high rate of teenage pregnancy in the UK and the issue of HIV/AIDS has meant that schools are seen as having an increasingly important role in the promotion of health of pupils and their communities. Health education in schools has, therefore, generally broadened to include sexual health education and drug education

While sexual health education is becoming a more established part of the PSE curriculum in Scottish secondary schools, there is still a great deal of variance in the approaches schools use to provide this type of education. Programmes are usually taught by teachers but some may involve health promotion workers and other specialists. Faced with demanding time-tables, schools welcome 'off-the-shelf' resource packs designed by external services which save teachers' time in designing their health education programmes. However, the way in which these pack are translated into action in particular schools will vary on depending on a range of factors such as teachers' skills, the time available in the curriculum for the programme, the school's assessment of the suitability of the material for its pupils and the pupils' own responses to the programme.

This variance means it is often difficult to map and compare different sexual health programme approaches and models. The frequency and quality of evaluation varies, making it difficult to assess what types of sexual health programmes are effective. Furthermore, there is as yet no consensus on what constitutes outcome measures for effective programmes. There is now a growing debate on what impact sexual health programmes (and other health programmes) can be realistically expected to have. To date, expectations for the outcomes of such programmes have been quite high, aiming to effect behavioural change across large numbers of individuals. There are parallels in this situation with drug education approaches where the complexity of influences on behaviour, range of approaches, the various value stances of interested parties and varying levels and quality of evaluation have meant that there is much still to learn about drug behaviours and what can affect them (Coggans and Watson 1996).

There has been some attempt to define the characteristics of a potentially effective sexual health programme. A British Medical Association and Sex Education Forum seminar (1996) on research into the outcomes of school sex education reflected on the literature and views of key participants drawn from a range of research, health and education fields. One of the results of this seminar was to highlight the characteristics of programmes which have been found to be effective in terms of behavioural and health outcomes. These programmes:

- focus on specific behavioural objectives (eg delaying intercourse or using condoms).
- have a theoretical grounding in terms of how action is affected by understanding and beliefs.
- have a minimum of 14 hours tuition or teaching in small groups - the latter allows for a more efficient use of time.
- use active learning methods which involve pupils and help them to personalise information.
- convey accurate information about risks of unprotected sex and how to avoid them.
- address social pressures on young people (eg ways of responding to a partner's attempt to persuade them to have sex).
- adopt clear values and messages appropriate to the pupil's age and experience (eg promoting delay in first intercourse for younger ages but emphasising condom use for older groups who are more likely to be already sexually active). No programme using an abstinence/no sex before marriage message has been found to be successful.
- use activities to practise relevant communication and negotiation skills and increase confidence in using such skills.
- adopt effective training for teachers/educators who provide the programme.

This seminar on school sex education also observed that few apparently effective programmes have been replicated or re-evaluated at a later date. Therefore, caution has to be used in applying an approach which has been judged as effective in one context to another or when adopting it more widely. Programme design and implementation should consider the possibility of differences in needs, ethos of a school, skills and commitment of teachers, pupils' background and wider social/cultural context.

It is also important to note that when programmes have an emphasis on specific behavioural outcomes they may also achieve broader, less measurable, outcomes such as enhancing the quality of relationships. Even when programmes are rigorously evaluated it can still be difficult to disentangle the effect of the programme from socio-economic and cultural influences. Random fluctuations in a population's health indicators mean that smaller scale statistical work has difficulties in identifying which factors affect sexual health. Large samples and complex longitudinal studies are needed to make confident assessments about the relationship between sex education and behaviour such as unwanted pregnancies.

While large scale studies can look for statistically significant changes in behaviour and associations with certain programmes, smaller studies using qualitative methods can be useful in illuminating the perceptions and needs of participants (pupils, teachers and external agencies) concerning sexual health education. Qualitative work can be particularly useful in exploring the relevance of a programme for pupils and their schools and the contextual influences on sexual health courses and the actions of pupils. For these reasons qualitative work can help identify what outcome measures larger studies can use, helps to make sense of the findings of large surveys and supports the development of practice. In particular, this type of research is also suited to identifying the key skills needed to teach sexual health education and effective training in developing these skills.

While debate continues on what approaches sexual health programmes should adopt and what evaluations should be measuring, most commentators would argue that the aim to provide sexual health education is important and that programmes should be evaluated. It was with this belief that the Greater Glasgow Health Board (GGHB) commissioned the Scottish Council for Research in Education to evaluate a pilot sexual health programme intended for use with secondary schools. This report focuses on the findings of the last in a series of evaluations of a sexual health education programme in one school. The findings of this final study are put in the context of the overall sexual health model developed by the GGHB in pilot schools in Glasgow during the period autumn 1993 to summer 1996. Given the remit and available resources for the research, each evaluation was small-scale and primarily used qualitative approaches. The strength of the overall findings are not in any statistical levels of confidence but in the illumination of participants' perceptions of their needs and suitability of the programme as it changed. In particular, these evaluations have highlighted some of the classroom and whole school processes which influence sexual health education.

2 A sexual health education model developed by the Greater Glasgow Health Board

An evolving sexual health education model

The sexual health education model developed by Greater Glasgow Health Board is part of an on-going effort by the health board to design a school-based approach for use in areas of multiple deprivation. A number of schools approached the Health Board for help to develop a sexual health programme is a pilot for this overall aim. Some of these formed pilots for the Health Board's model.

The approach has evolved over the past three years but has always been grounded in a belief that pupils should explore their own lives in regard to sexuality and sexual health, emphasises pupils' ownership of issues and challenges misconceptions and myths with factual information. The main aim of the programme is to 'raise awareness of the meaning of full-sexual well-being, encourage informed choice, and discourage unplanned pregnancy' (Greater Glasgow Health Board: Health Promotion Department 1995). The actual coursesprovided for different classes work towards this aim adopting a non-judgmental ethos and moving between whole class, small group and individual work.

The Health Board has had a key role in designing the sexual health programme curriculum in association with the pilot schools, providing training and advice on materials and teaching approaches for use in sexual health. The SCRE evaluation focused on the programme as provided in one pilot school.

The pilot school

The school has approximately 660 pupils and 60 staff and is situated in a large urban housing estate on the outskirts of Glasgow. It is recognised as an area of multiple disadvantage and is designated by the regional authority as an Area for Priority Treatment. Health board statistics for this area show the number of women under the age of twenty who were having children is far higher than the average for the Greater Glasgow area. This context provided part of the rationale for developing a sexual health education model in this community particularly relevant.

The model translated into practice

From the start of the collaboration between the pilot school and Greater Glasgow Health Board in 1993, the main aims of the two parties was to develop an approach which would meet the needs of the pupils and school, be sustainable and be provided by teachers. The Health Board emphasised that the school should have ownership of the programme and its negotiations and work with the school have been guided by this principle.

In the pilot school where the sexual health model was evaluated, the approach was adapted to suit the particular needs of this school. In the first phase of the model (1993-

94), the programme was provided in one PSE lesson each week for 10 weeks. The assistant head teacher and all involved in the teaching of the PSE curriculum negotiated content with GGHB but did not teach. Health workers taught the programme during this phase. The initial use of health workers to teach on the programme was mainly due to the teachers' request for assistance in teaching topics which were complex and sensitive. At the beginning of the collaboration, the teachers were unsure about their skills and subject knowledge to provide a programme of sexual health education.

The second phase lasted four weeks and PSE teachers taught two of the four sessions alone. Health workers from GGHB led the other two co-teaching sessions. This can be seen as a transition year with the duel aim of introducing teacher delivered sexual health education to pupils and, at the same time, provide experience for teachers.

The third and final phase saw the programme taught by teachers only and ran for five weeks. The teachers still had access to advice provided by health promotion staff at GGHB. Throughout the three phases each programme was taught to pupils as part of PSE curriculum and can be seen as an experiential learning approach moving between whole-class, small-group and individual work.

The content of the programmes over the three years was based on negotiation between GGHB and the school. The content seen as appropriate and relevant for pupils of different year groups was agreed and varied depending on year group being taught. The topics over the three years were refined based on experience and the SCRE evaluation. They typically included:

S1: Talking about sex, Puberty, Menstruation, Young peoples' opinions on sexual health

S2: Learning about relationships, Being a boy and being a girl, Media images, Legal issues and sex

S3: Language, Contraception, HIV & STDs, Safer sex, Making decisions

S4: Pregnancy, Assertiveness, Negotiating in a relationship, Working out what help you need

S5: Introduction, Video and discussion, Language and our bodies, Safer sex and sexual choices, contraception and pregnancy.

A range of teaching methods were used in each phase including discussion groups, self-completion and reading material, video, some role-play (Phase 1 and 2 only) and quizzes. In the final phase (1995-96) the S5 year group teaching methods included a project. Classes were mainly single sex but one session, a role-play, was mixed sex. In the final phase (1995-96) the S5 year group teaching methods included a project. Further details of the sexual health education model provided in the school are given in a detailed summary of the different phases in Appendix 1.

The model aims towards teachers and pupils sharing a common language. The rationale for this is to aid the pupils' empowerment and reduce potential language barriers which would hinder communication and discussion. Therefore, the model seeks to avoid examining 'the most personally intimate subject in a culturally estranging way' (Greater Glasgow Health Board: Health Promotion Department 1995). Lessons are believed to work best if discussion is free enough to let pupils direct the class within reasonable limits. The aims and approach of the programme are challenging for teachers and pupils alike as they often have to re-address their classroom roles, perceptions, expectations and interaction.

The model adopts a 'spiral curriculum' which revisits the subject of sexual health annually to deliver more detail and subject content as appropriate to match the development of pupils and their changing needs.

> *The early years focus on concrete issues introducing clear information, examining decision making and wider issues. Later years enable more abstracted education and discussion, focusing more acutely on training in relationship skills. The programme finishes in an open-ended module for Year S5*
>
> Greater Glasgow Health Board: Health Promotion Department 1995

Training for teachers forms a key component of the model. As well as helping pupils towards informed opinion and decision making the model also recognises the importance of developing teachers' skills in providing sexual health education. The training which is provided by Greater Glasgow Health Board Health Promotion Department staff is recommended as being at least one day spent on sexual health in general followed by a Parent and Teacher night looking at issues associated with curriculum implementation. Teachers are encouraged to explore their own attitudes and concerns about working in this area.

The Health Board has also recommended that the programme be phased in its implementation. For example, Introducing S1 in the first year, then S1 and S2 in the second year and so on. The Health Board believes that this phased approach enables them to better support the introduction of the programme with an annual training session for teachers.

The role of the SCRE evaluation

In 1993 the Scottish Council for Research in Education (SCRE) was commissioned by The Greater Glasgow Health Board to evaluate the first phase of the programme and the same research team was subsequently invited to evaluate the next two phases (Please see Appendix 2 for details of the evaluation aims and approaches). All three evaluations aimed to assess whether pupils, teachers and the Health Board perceived the programmes as relevant in terms of meeting the sexual health needs of pupils and also whether the needs of teachers as providers of the content were being met. The full findings of the evaluations of the first two phases have been published (Lowden and Powney 1994. Lowden, Hall, Finnigan, and Powney 1995).

The evaluation of the first phase of the project adopted a mainly qualitative approach and used single sex group interviews with three classes selected from each of the year groups who experienced the programme. Pupils also completed open-ended question sheets and teachers and health workers were interviewed. Information was gathered before and after the programme to assess whether participants' perceived needs were being met. The second and third phase evaluations adopted a questionnaire approach with group interviews of two S1 and two S5 classes to illuminate and inform the questionnaire data. As before, teachers and health workers were interviewed and data were gathered before and after the programme.

The evaluation methods worked well in eliciting the perceptions of pupils, their teachers and the health workers. The findings were useful in adapting the programme from one year to the next and highlighting wider issues. Group interviews with girls usually worked better than those with boys in terms of volunteering information and discussing viewpoints. Girls seemed to discuss many of the issues covered by the research in their day-to-day talk and found it reasonably easy to discuss sexual health education in a research context. In contrast, boys usually appeared not to discuss sexual health

topics in detail with peers and when they talked in groups their discussion could be influenced by their macho attitudes and defensiveness.

With hindsight, the evaluation would have benefited from surveying more pupils (ideally all pupils). Even if one class from each year group is surveyed, when the data are analysed by year group and sex of respondent the numbers of pupils falling into analysis cells are too small for significant statistical conclusions to be made. The consistency of responses and findings on particular issues and topics was a useful check on their validity but greater statistical scrutiny would have enhanced the evaluation.

Review of the sexual health model

An overview

At the outset, the aim of the Greater Glasgow Health Board was to develop a sexual health programme model which could be provided in secondary schools, which met the needs of the pupils and their teachers and was sustainable. The model was concerned with gradually shifting major responsibility for the content and delivery of the programme from Health Board staff to teachers. The ownership of the programme was always meant to be with the school but support, training and advice from the Health Board would be available as necessary and if requested by the school. Alongside these developments there were changes in the length of the programmes (10 weeks in phase 1, to 5 weeks by phase 3) and corresponding adjustments in the content of the programme. (Appendices 1 and 2 summarise the three phases of the model and the evaluations).

The findings of previous evaluations are summarised and compared in Appendix 3 but the overall impression of the findings of the three evaluation is a positive one. In looking back over the three evolving phases and the corresponding evaluations of the individual programmes, it is evident that the sexual health model is still evolving and is being refined but that it is meeting its aims as a relevant and feasible curriculum-based programme. Using some of the main aims of the model we can look at how well it has met these and what still needs to developed.

Did the model raise pupils' awareness of sexual well being?

The three evaluations have shown that the majority of pupils have reported the programme was addressing topics important to them in an interesting way and that they valued the sexual health programme. One of the aims of the sexual health model was to 'challenge misconceptions and myths with factual information' and each phase has shown pupils' knowledge of the sexual health topics covered has increased. Most pupils claimed they had improved their understanding of sexual matters. In the case of S1 and S2 pupils the anxieties they had about the physical changes they were going through was ameliorated by the provision of factual information.

There are still some issues that need to be addressed in terms of content. One of the most important is matching the programme content and methods to the needs of S5 pupils, especially those of young women in this year group. Some of these young women still feel reticent about discussing sexual health and behaviour issues with the teachers. Teachers are aware of this issue and have suggested that perhaps appropriate outside providers could deliver content which teachers and pupils feel they cannot usefully discuss. Fortunately, this seems to relate to small amounts of the S5 curriculum but it does highlight the one area where teacher-led sexual health programmes are limited.

Enhancing pupils' ability to make informed decisions

The evaluations looked at each one year phase of the model separately and did not follow individual pupils in a longitudinal study. Therefore, there are limits to what can be said about the programmes and their effect on pupils' actual decision making concerning sexual matters and, for example, the impact of the programme on, unplanned pregnancies – such a correlation is often very difficult to establish. However in each evaluation most pupils claimed that they thought that what they had learned would be useful in terms of improving their ability to make informed decisions.

The qualitative group interviews were particularly informative as some pupils (usually S4 and S5) would demonstrate how aspects of their programme had made them assess sexual decisions and often act in the light of what they had learned (for example, practising safer sex or avoiding sex if they did not really want it). These pupils also highlighted the difficulties of translating classroom-based information and skills to the real social world of young people. Pupils said that learning about sexual health in a classroom could be quite different to an emotionally charged situation, especially when alcohol was involved. Sexual decisions, even when young people are confident and knowledgeable, can be extremely complex and what is learned in schools will sometimes be limited in its impact.

Promoting teachers' confidence and skills to provide sexual health education.

The first evaluation saw health board staff providing all of the programme because teachers were ambivalent about their roles and skills in teaching a sexual health. However they were willing to obtain the necessary skills and eventually to play an active role in teaching sexual health courses. From the second phase of the model, where teachers worked alongside health workers in providing some of the content, there was a sharp rise in their confidence. Pupils reported finding teachers far more acceptable as providers of sexual health education than they had first thought. With the third phase of the model, teachers provided all of the content and felt that their skills and confidence had been further enhanced. The high quality of the training teachers received was given as oneimportant reason for their abilities and confidence; actual experience of teaching this type of content had also been the other major factor in improving their skills and confidence.

While the teachers have gained confidence and skills concerning the teaching of sexual health education and have been seen by most pupils as appropriate providers, the teachers are aware that more work has to be done on communicating about some sexual topics with older pupils, particularly S5. In some cases external providers, such as health workers, might still be needed for occasional sessions on those topics teachers and pupils feel are best taught by personnel who are somewhat distanced from the traditional role of the teacher.

Pupils are often more likely to open up to healthworkers who have expertise in both the subject area and in discussing sensitive topics. Their role as outsiders means they can distance themselves from the image and role of teachers which can inhibit openness from pupils. At the same time they can follow ground rules and guidelines which are complementary to those of the school. However, resources will usually limit the role health workers can play in the teaching of the programme content even if their presence is requested by the school and pupils. Consequently, health workers seem to be most effectively employed in helping schools design programmes, training staff and highlighting relevant materials and approaches.

Encouraging peer-support within the school to counter sexual pressure and embarrassment over body changes

Another aim of the model is to encourage peer-support in classes through educating pupils about sexual health facts and helping them to make their own decisions. The information gathered from pupils has shown that the sexual health education can affect the 'peer culture' of pupils. By informing pupils, dispelling myths and challenging certain views, the ethos of pupils can be affected. Pupils reported in the evaluations that when whole classes and year groups were given a sexual health programme, negative peer influences were weakened and peer-support emerged.

Sex was more likely to be seen 'in perspective' rather than as a mysterious, all-important issue. This reduced some of the pressure and anxiety concerning sex and sexual decisions particularly among girls and S1 and S2 boys. The importance of improved sexual knowledge about body changes and puberty was especially appreciated by S1 and S2 pupils. Dispelling sexual myths also reduced worries and improved pupils' self-confidence.

It is often difficult to get an accurate view on how well pupils counter sexual pressure and make decisions. Self reports can often be rationalisations. However, pupils did claim that the programme had been useful

Conclusion

Overall, the model of a sexual health education programme as it has evolved in this pilot school has taken considerable time and resources but these appear to have been a good investment in the production of a sustainable, relevant school-based sexual health programme. The pilot has:

- led to a curriculum which meets the sexual health needs of the majority of pupils;
- developed and enhanced teachers' skills;
- promoted teachers' confidence in providing sexual health education;
- highlighted the limits of teacher-led programmes.

The first phase of the model (10 week, health worker only) helped sensitise the health board to the needs of pupils and their teachers and to what could realistically be provided in a school. The second phase (four week, teacher and health worker led) further developed the skills of teachers, refined materials and formed a sustainable curriculum. The final phase (5 week, teacher only but supported by Health Board training and materials) has the potential to be adopted by schools as a relevant and sustainable approach. A revised sexual health programme has now been designed out of the experience gained from the three phases. If the model is used as an overall framework but allows the content and approaches to be fine-tuned to individual schools' context and needs, it should contribute to the sexual health of pupils and the skills of teachers to provide this type of education.

One potential problem with the model as it now stands is that the Health Board favours a phased implementation of the programme, with S1 receiving it then S1 and S2 the following year and so on. By doing this the Health Board feel they can better train and support teachers. However, this might be resisted by some schools who want a complete programme introduced for all year groups in one go. One also wonders whether those pupils who are awaiting the programme while younger peers are receiving it might feel somewhat overlooked. More importantly, what will be done to meet the sexual health

education needs of those pupils who do not receive such a programme because their year group fell outside the first year to receive the programme? Can a school be expected to run two programmes until the new one is completely phase in?

In general, the Greater Glasgow Health Board sexual health education model would seem to be one which is transferable to other schools who are willing to adopt its underlying ethos and collaborate with a health board to 'fine-tune' the approach to suit the needs of pupils.

3 Themes and issues

This chapter summarises the main themes and issues to emerge from the evaluations of the sexual health programme provided collaboratively by the school and the Greater Glasgow Health Board over the period 1993-96.

Context

- The situation in the catchment area for this school has changed little over the three years of the evaluation. There continues to be an apparent level of sexual activity among teenagers in the community where the school is located and pregnancy rates are high compared with the rest of the country. These characteristics helped to provide the rationale for a school-based sexual health programme and also shaped its content. The programme has been developed from work in pilot schools and this report concerns the evaluation of the programme as provided in one of these schools.

The sexual health model

- Overall, the sexual health model and its constituent programmes has demonstrated a fruitful collaboration between education and Health Board services. The effort this required by all the participants should not be underestimated. There are different professional traditions, planning timescales, expertise and levels of confidence about the subject matter and about working in classrooms. The teams working on this programme were willing to negotiate and periodically renegotiate in the light of experience. Health workers supported teachers with a training programme and teachers had the courage to tackle new topics even when they were quite apprehensive about doing so.
- There is no doubt that the pupils appreciate the existence of a sexual health programme which provides them with core information and opportunities to discuss whatever is of interest or is worrying them. As those working in the field are well aware, some topics are more easily covered than others. Bodily changes, facts about conception, sexually transmitted diseases, HIV/AIDS - these are areas where there is accurate information which everyone should know. They are also the topics where (other than perhaps some initial embarrassment) it easiest for pupils and teachers to work together on.

Communication and relationships

- The more difficult topics in any sexual health programme concern values and relationships and the decisions facing young people as they grow up and extend their sexual opportunities and experiences. Three reasons why they are more difficult are because: they are more complex than facts; they depend on trusting and confidential relationships between peers and between pupils and teachers

and other adults involved; they concern actions which could elicit disapproval from peers and teachers and/or could be illegal – for example, if a pupil aged fifteen or younger was involved in a sexual relationship with an older pupil and was seeking advice from a teacher on contraception, safer sex or options available should the girl become pregnant. This could pose a dilemma for a teacher. Does the teacher provide information on where to obtain contraception and condoms or does he or she follow the official line, telling the pupil that this behaviour cannot be condoned and should be stopped? The teacher may even feel it necessary to report the pupil to the head teacher.

- Tensions can, therefore, exist between teachers' roles and responsibilities and young people's need for confidential advice. While pupils would like to be able to confide in and obtain advice from some of their teachers, they are reluctant in case the teacher breaks confidentiality or judges the pupil. Pupils are not just worried about teachers spreading confidences around the staff room but that the teachers might see it as their duty to take action. This is the dilemma for teachers who are required to follow certain procedures concerning pupils' behaviour which could run counter to supporting them in difficult circumstances.
- Pupils can believe that a teacher will be too embarrassed to discuss important issues with them or be restrained by their role as teacher. These pupils can also feel embarrassed about talking to a teacher about aspects of sexual health. Training for staff and experience of providing this type of education can help to promote teachers' abilities in responding spontaneously to the questions asked by pupils and promote active discussion between teacher and pupils. Indeed, the training provided for the programme attempts to develop discussion approaches pupils and teachers can use to cover sensitive issues which are salient to the pupils without personalising the discussion. Techniques are adopted in groups where salient issues are covered in a fashion that does not reflect on an individual's behaviour; hypothetical scenarios or stories are also used. The evaluation suggests that the training in these skills needs to continue to improve how teachers promote discussion and respond to pupils' questions.
- Training can help promote discussion skills but it seems that more dialogue and communication between teachers and pupils on the rationale for the programme content and the limits to what teachers can discuss or keep confidential might help teachers and pupils better understand each others' situation and improve trust and coverage of certain topics. Some pupils, especially those in S5, can be unsure of the reasons for their curriculum content and become frustrated if the relevance of content or a particular teaching approach is not made clear.
- Schools can examine how teachers can develop further their skills in discussing certain sexual health topics with pupils. Teachers' communication and rapport with pupils might be impeded by the factors identified in this chapter, but is this inevitable? PSE teachers are, ideally, already skilled in developing rapport with pupils and developing their knowledge and skills. Training to provide sexual health education programmes further enhances these skills.

Teacher characteristics valued by pupils

- The evaluations of the sexual health programme over the past three years have highlighted what pupils see as the ideal qualities a teacher should have to teach this subject. Pupils seem to be willing to engage more fully in the learning

experience if their teacher: treats them as responsible young people with their own opinions; respects their point of view but is willing to challenge them; responds to their questions and is not evasive; demonstrates competence in the subject matter and upholds confidentiality.

- Given appropriate experience, training and commitment, these qualities do not seem to be beyond the reach of teachers and schools. However, if certain barriers still exist and preclude easy free-flow information and question and answer style teaching, then the subject essentials can be covered by teachers supported by collaboratively designed materials. The more complex needs of pupils might then have to be met by other services (such as health workers) and delivered within or outside of school.

The role of external providers

- If, for whatever reason, teachers are not approachable for all parts of the content of a sexual health programme this raises the questions who is best suited to teach the more sensitive aspects of the curriculum and what can a programme be reasonably expected to cover and achieve? Should other providers be available to take forward sexual health education for older pupils' when the school has done all it can?

- Having skilled outsiders (health promotion staff, family planning nurses, or doctors) to provide aspects of a sexual health programme can ameliorate some of the problems associated with the (perceived and real) role of teachers and their teaching of such programmes. The benefits of using external specialists to teach can include pupils being more willing to discuss sexual health topics and their needs with someone they will not see on a day-to-day basis. Such people are also perceived by pupils as being less likely to judge their behaviour and take disciplinary action. Generally, pupils view relationships between themselves and health workers as more egalitarian than with teachers.

- This can mean that a programme using external health education specialists to provide part or all of the teaching can be more responsive to pupils' needs. However, there are also related implications such as how sustainable are parts of a programme that has to 'buy-in' external teaching? What quality assurance and checks are there to ensure this teaching is suitable to pupils' needs, assures confidentiality and conforms to the school's own principles and guidelines? Also, what impact does the substantial and continued use of external teachers have on the school's ownership of a programme?

The role of peers

- Some pupils suggest that older pupils who are seen as responsible yet credible could be used to provide parts of the programme. Some older peers are role-models and an influential source of information on sexual health. However, pupils are also aware of the implications of such peer education. They stress the possible problems with confidentiality and the need for such peer-educators to be skilled and up-to-date on factual information. These are necessary attributes but these skills and knowledge are difficult enough for adults to acquire, therefore, the training of peer-educators would be especially important.

The impact of time and resources

- Pupils are critical consumers and in circumstances where they do have an opportunity to contribute to the design of a programme or to give feedback, they can make their preferences and needs known. Even the most responsive teachers however do not have infinite time and resources; they are responsible for ensuring that overall curricular demands are met within timetabled time. There remains a tension in almost all subjects, not just sexual health or PSE, between covering a planned course which in most subjects means preparing for an examination and seizing the opportunity when pupils express interest or need to follow a different track or provide more detail. For example, when a video is used in the programme this, as intended, will often trigger discussion. However, the lesson is usually not long enough to cover all the questions raised. In any of the lessons on the sexual health programme a range of questions can emerge, some of these might be tangential to the lesson topic but important nonetheless
- Ultimately, teachers have to be extremely clear about the purpose of their programme. If, as in this case, a major aim is *to raise awareness of the meaning of full sexual well-being, encourage informed choice and discourage unplanned pregnancy*, teachers will adopt methods which encourage pupils to be active participants in their learning. Also, *informed choice* entails a reasonable knowledge base and access to resources to enhance that knowledge when new demands occur. Pupil-centred learning supported by appropriate resources is appreciated by pupils and can be effective but can place great demands on the school given the requirements placed on time and resources of the wider curriculum.

Meeting the varied needs of pupils

- Resources and time are important but so is the appropriateness of what is provided for pupils' age and stage in their development. In any one class of secondary students there will those with little knowledge or practical experience of sex and others who are already sexually experienced and possibly into sustained relationships. How can a curriculum suit people with these profiles? It is clear from this pilot school's experience that it will have to be a spiral curriculum where similar topics are revisited in the expectation of pupils having moved on. This can be enhanced where teachers are able to respond to questions salient to a particular group of pupils or an individual.
- There also needs to be resources available for easy reference for pupils who may not have had the time to fully discuss topics within the lesson or who may have felt inhibited from talking about their needs. However, providing readily available reference material is not an easy task as pupils may not notice, or want to be seen using certain materials – for example, reading a notice in a main school corridor on where to get contraceptive advice. Also, they may not trust printed material without being able to discuss it or still be reticent about approaching external services even if they are aware of them.

  The clearest example of the latter has been from S5 girls who say that they do not get enough advice about what to do if they suspect they may be pregnant. The programmes provided at the pilot school provide clear information about agencies who are available for consultation but the girls are reluctant to go to such places as they assume they will be patronising and judgmental. This implies that pupils need not only to know where to get further advice and information but also

what the service's ethos and nature is. It has been suggested by health promotion staff that often the most effective way of doing this is to take pupils on a visit to an organisation which provides sexual health advice.

- The health promotion staff involved in the programme design and training have, since Phase 2 of the programme, stressed that the content could evolve further to cover the topic of what S5 pupils can expect from sex. In particular, the positive and pleasurable aspects of sex have so far been a background issue but seem relevant to this age group. Health promotion staff commented that girls did not always associate sex with personal pleasure but rather as a way of "keeping their man". Increasing pupils' awareness of enjoying sex, while important and worthy of inclusion to a curriculum, could require teachers and pupils to communicate particularly well to discuss needs and ways to promote enjoyment from sex.

Sexual health education: important but realistic goals

- The contributions to young people's sexual health made by any school are necessarily limited by time and by the supportive or countervailing pressures of the environment. The evaluations of the sexual health programmes over a three year period indicate that a school-based programme can reasonably be expected to play a limited role in the totality of education given the numerous and complex interacting factors which affect sexual health. Nevertheless, the importance of school-based health education should not be overlooked as it can be a contributing influence in promoting pupils' health and the impact could be lifelong. For example, if young people adopt safer sex behaviours this can obviously help promote their long-term health by greatly reducing the risks of sexually transmitted diseases. The benefit to the individual and community are obvious but there will also be savings for those health services which would otherwise have to treat individuals. The same argument applies to any effect in reducing unwanted teenage pregnancies.
- Schools and teachers provide information which pupils consider reliable but there are also other important influences on sexual attitudes, knowledge and behaviour. The school is a social network where older pupils are not only sources of information but also role models for the younger ones. Siblings, friends and family all contribute to what is usually a gradual increase in knowledge and understanding of sexual matters. Schools and teachers can make a useful contribution to individuals' welfare but they do not carry the full responsibility for sexual health education.

The challenge for the future

- This evaluation has highlighted the positive effects of a sexual health programme which was modified over three years in the light of formative evaluation and according to the time and other resources available. The remaining question is how can such programmes be developed to meet the changing needs of pupils and resourced and staffed to maintain continuity and quality of provision. Changes in key and trained personnel could have a detrimental impact on the continuity of sexual health programmes.

Section 2: Evaluation of the third phase of implementation

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4 Phase three of the sexual health education model

The sexual health education model: Phase 3

Evaluations of Phase 1 and 2 have already been published by SCRE. The rest of this report reports the evaluation of Phase 3 of the sexual health model. The third phase of the sexual health education model continues to work towards the overall aims of the total initiative and adheres to the aims and ethos of the overall model as described in the previous chapter. These aims emphasise:

- Providing accurate and relevant sexual health information
- Promote pupils' ownership of their own sexual health issues
- Developing pupils' informed decision-making abilities concerning sexual activity through
- Encouraging peer support within classes

This third phase marked the move from a co-taught approach to one which relied solely on PSE teachers to deliver the content. The third phase is, therefore, the method which will be used in the school for the foreseeable future. The programme used in the school will be responsive to feedback and evaluation and evolve, as necessary, but the overall framework will still involve teachers as the main provider of the programme.

The third phase delivered in 1995/96 was taught to S1-S5, mainly in single sex groups as part of the PSE curriculum (with one discussion session for a mixed group). While teachers deliver the total programme they have access to advice provided by health promotion staff at Greater Glasgow Health Board.

The programme's content had been amended slightly from the previous year on the basis of experience and evaluation and the topic covered were:

S1: Talking about sex; Puberty and the body; Sexual body parts; Menstruation; Young peoples' opinions on sex

S2: Where do we learn about relationships? Being a boy and being a girl; What is perfect? (Media images etc); Everyone is different; Legal issues and sex

S3: Language game; Contraception; HIV & STDs; Safer sex; Making decisions

S4: Pregnancy; Communication; Power in relationships; Pressure Lines (resisting unwanted pressure regarding sex); Getting the help you need

S5: Project based work geared to enabling students to examine in detail sexual health issues that affect them.

The PSE teachers used approaches, programme materials and resources designed by the Health Board. These had been based on the Department's experience and also adapted through consultation and negotiation with the school. The teaching methods included: instruction; discussion; video; self-completion tasks and reading materials; video and quizzes. No role play was used but S5 work involved a project.

Evaluation approach

This evaluation focused on participants' views on the effectiveness of the third year of the programme and used the same evaluation approach as that used for Phase 2. The main aim of the evaluation was to address the question:

> *How effective is the teacher-led sexual health programme in meeting the sexual health education needs of secondary school pupils in the target school?*

The specific research questions used to address this main aim were:

- How satisfied are the participants (pupil, teachers and health workers) with the new, teacher-led, programme in terms of meeting pupils' sexual health needs?
- What fears, hopes and expectations, if any, do the participants have about the teacher-led method of delivery?
- What are the benefits and disadvantages of the teacher-only approach compared to approaches involving inputs from health workers?
- What do participants see as the characteristics of good teachers in this field?
- What training, support and resource material needs do teachers have before and during the programme? What, if any, outstanding training needs do teachers have? Also, how do teachers and health workers gauge the importance of previous training for teachers now involved in leading the sexual health programme?
- What, if anything, would participants like to change in future programmes?
- What factors do participants feel affect the success and sustainability of a teacher-led sexual health programme?

The methods entailed one PSE class in each year (S1-S5) being surveyed before and after their programme (130 pupils pre-programme and 99 post-programme). The questionnaires contained mostly open-ended questions with further items on satisfaction ratings. Two classes from S1 and S5 were interviewed to gather illuminative information about pupils' sexual health needs and perceptions of the programme. Before and after the programme, all PSE and guidance teachers involved in teaching the course were interviewed as groups. The health promotion worker who had trained and advised the school was also interviewed.

The resulting evidence consisted of the following:

Pre-programme

- Questionnaire data from 133 pupils
- Interview information from 2 S1 and 2 S5 classes (approximately 20 pupils in each class)
- Interview information from all 10 teachers who worked on the programme

• ***Post programme***

- Questionnaire data from 99 pupils
- Interview information from 2 S1 and 2 S5 classes (approximately 20 pupils in each class)
- Interview information from all teachers who worked on the programme

Before, during, and after the programme the senior health worker who was working with the school was consulted to obtain information, to clarify emerging issues.

The statistical computer package SPSS was used to analyse the questionnaire data and the topic headings from the semi-structured schedules used in the group interviews were used as the framework for the qualitative analysis. The headings use to arrange the following chapters' description of the findings are mostly based on the questions used to gather our data.

Table 1 provides the numbers of pupils completing questionnaires, broken down by sex and year group.

Table 1: Numbers of males and females in each year completing questionnaires

Year	Males		Females		Total	
	Pre	Post	Pre	Post	Pre	Post
1st	12	13	10	12	22	25
2nd	8	7	13	14	21	21
3rd	11	8	5	9	16	17
4th	12	6	9	11	21	17
5th	21	7	29	12	50	19
Total	64	41	66	58	130	99

The table shows that in many cases, fewer pupils completed the post-programme questionnaire compared to the pre-programme questionnaire. This is most pronounced in the case of the S5 pupils. This appears to be due to the pupils not being available when the post-programme questionnaire was administered rather than a refusal to complete the questionnaire.

5 Pre-programme evaluation findings

The evaluation findings for the Third Phase of the programme are presented in two main sections, the first, Chapter 5, looks at the pre-programme findings drawing on evidence from pupils and adults involved with the programme. The second, Chapter 6, reports the findings from data gathered from pupils and adults immediately after the programme. Where the findings based on questionnaire data are reported they are usually broken down by gender and age group to allow more useful interpretation. However, this means that the actual cell sizes are low and it would be misleading if percentages were used. Therefore, in most cases, actual numbers of responses are given along with the number of individuals who answered the question. Where appropriate, we have integrated the qualitative information gathered from the group interviews with S1 and S5 pupils to illuminate and further explore findings emerging from the questionnaires.

The views of pupils

One hundred and thirty pupils completed the pre-course questionnaire which aimed to assess what their interests and concerns were in terms of the sexual health programme.

What topics did pupils want to learn about most?

Using an open-ended question, pupils were asked what would be the most important topic they would like to learn from programme. Table two gives their responses by year group and sex.

Table 2: Pre-programme - most important topics pupils wanted to learn from the course - year and sex (frequency of responses)

Year	Males		Females	
1	Development	3	Development	6
	Pregnancy/abortions	2	Sexual health general	1
	Everything	2	R'ships/feelings	1
	Sexual health general	1		
2	Development	3	Sexual health general	4
	AIDS/STDs	2	Development	3
	Everything	1	R'ships/feelings	2
	Sexual positions	1	Pregnancy/abortions	1
3	AIDS/STDs	5	AIDS/STDs	3
	Sexual health general	2	Sexual health general	1
	Safe sex/contraception	2		
	Everything	1		
4	AIDS/STDs	6	AIDS/STDs	6
	R'ships/feelings	2	Safe sex/contraception	2
	Pregnancy/abortions	1	Pregnancy/abortions	1
	Everything	1		
5	AIDS/STDs	8	Pregnancy/abortions	13
	Safe sex/contraception	3	AIDS/STDs	7
	R'ships/feelings	2	Sexual health general	3
	Sexual health general	1	R'ships/feelings	2
			Safe sex/contraception	1

These responses combined with evidence from the group interviews show that the mid to upper school were interested in learning about HIV and other STDs while the lower school wanted to learn mainly about physical development and puberty and sexual health advice in general. Wanting to know more about STDs was motivated by anxiety based on not knowing enough about how to protect themselves. The S1 boy and girl groups wanted to know about sex in general to better prepare them for when they started to have sexual relationships. These interests are generally similar to those of the same age groups reported in the previous evaluation; then, the S5 girls also wanted to learn about pregnancy and related options such as abortion. The group interviews illuminated why almost all S5 girls were predominantly concerned about pregnancy issues (20 girls out of the 24 in the two S5 groups).

In exploring these issues with one of the S5 girl groups, it emerged that most of them claimed to be sexually active and, therefore, needed to know about pregnancy and related issues and options should they become or wanted to avoid being pregnant. This group felt that girls were not given detailed information on pregnancy issues in school before they were sixteen because of teachers' concerns about giving advice involving underage sex.

These young people pointed out that a lot of teenagers got pregnant and it was implied that teenage sex and pregnancies are a normal part of their world. Despite this, the S5 girls were not aware of any detailed advice being available about the issue of teenage pregnancy. There was uncertainty about where to find this information and when girls knew about a source they were unsure about how approachable the service was and were afraid of being 'judged'. These young women were unaware of the non-judgmental ethos and approach of such services.

Whereas younger pupils wanted to know about the topics they specified out of curiosity and to a lesser extent as a preparation for sexual relationships, the S4 and particularly the S5 pupils saw the information as being relevant to their current lifestyle.

Did pupils have any anxieties about the course?

Pupils responses to the open question about any specific worries or concerns about the forthcoming sexual health course are categorised in Table 3.

Table 3: Pre-programme: 'worries' by year and sex (frequency of responses)

Year	Males		Females	
1	Being shown up (no worries stated	1 7)	Mixed sex groups Being shown up (no worries stated	4 1 1)
2	–		– (no worries stated	3)
3	–		–	
			Talking about subjects	2
4	–		Being shown up Mixed sex groups	1 1
	(no worries stated	3)	Talking about subjects (no worries stated	1 2)
5	Teachers presence Mixed sex groups (no worries stated	3 2 5)	Teachers presence Being shown up Talking about subjects Being judged (no worries stated	8 6 1 1 7)

We can see that generally males expressed fewer concerns about the course than females. It is not clear whether this actually reflects fewer concerns or whether the boys were less willing to express any concerns. We know from the group interviews that boys are more reluctant than girls to explore sexual topics beyond a shallow level when in groups. We can also see that a small number of pupils were anxious about their participation in the programme, for example, talking about subjects and being in mixed sex groups.

While specific answers were coded, there is no doubt that the four categories emerging are unlikely to be mutually exclusive. For example, difficulty in talking about subjects and being shown up may be related to some pupils' apprehension about the possibility of being in mixed sex groups or the presence of their teacher.

Table 4 shows the expectations of pupils and what they were hoping to learn from the course.

Table 4: Pre-programme: what were pupils looking forward to? (frequency of responses by year and sex)

Year	Males		Females	
1	Learning general	10	Learning general	6
			(not looking forward	1)
2	Learning general	5	Learning general	11
3	Learning general	7	Having a laugh	2
	(not looking forward	2)	Learning general	1
			(not looking forward	2)
4	Talking about things	6	Learning general	6
	Learning general	2	(not looking forward	3)
	Seeing the health worker	1		
	(not looking forward	2)		
5	Learning general	9	Learning general	20
	Talking about things	4	Talking about things	1
	Having a laugh	1	(not looking forward to prog	3)
	(not looking forward	2)		

Overall, pupils were looking forward to the programme with most of them wanting to learn generally about the subject of sexual health but it is interesting that pupils (including 10 males in S4/S5) were also looking forward to talking about sexual health topics. This reflects the demand made throughout the evaluation by pupils in group interviews and the questionnaires for more opportunity to discuss sexual health. In the case of the S4/S5 boys it may also reflect the lack of opportunity for discussion about these topics in their male peer groups.

Where did pupils obtain the most useful information on sexual health?

Pupils were asked where they had got the most useful information concerning sex and sexual health. Results are presented in Table 5.

Table 5: Pre-programme: origin of most useful information by year and sex (frequency of responses)

Year	Males		Females	
1	Parents	2	Parents	6
	TV	2	Magazines	2
	Friends	1	Friends	1
	Newspapers	1	Videos	1
	Siblings	1		
2	TV	5	Parents	5
	School	1	Magazines	5
	Other	1	School	1
			Friends	1
			TV	1
3	School	3	School	5
	Friends	2		
	Magazines	1		
	Videos	1		
	Other	3		
4	School	3	School	3
	Magazines	2	Parents	3
	TV	1	Friends	2
	Video	1	Other	1
	Books	1		
	Other	4		
5	School	8	School	11
	Magazines	3	Friends	6
	TV	3	Magazines	5
	Friends	2	TV	2
	Parents	2	Books	1
	Other	3	Other	4

We can see that, generally, parents are more important as sources of information to S1 and S2 pupils; the older pupils report that school is the source of the most useful information. This might reflect S3 and older pupils' evaluation of the usefulness of information provided in the school's two previous sexual health programmes. Also, as our previous evaluation findings have shown, pupils from S3 onwards are less likely to see parents as approachable sources of sexual health information because of a fear of being seen as sexually active by parents and embarrassment between generations in discussing such matters. The school is rated highly as a source of information by the older pupils (despite criticisms of the programme by some S5 girls reported elsewhere in this report). This is important because it reveals a faith in the school as a source of accurate and useful sexual information. It also contrasts with the findings of other research which often claims older pupils value school-based sexual education less than other sources. This might mean that this Health Board's model for a sexual health programme has been more successful than other approaches in engaging the interest of pupils.

The group interviews allowed more in-depth exploration, elaboration and insights on how younger and older pupils obtained information about sexual health. Pupils stressed that a lot of their day-to-day information on sex comes from friends, mothers, cousins and fathers in that order. However, when it comes to reliable information and advice, the school becomes an increasingly important especially when, by S5, young people are less likely to approach parents

There were differences between boys and girls and different age groups in where they obtained information on sex. Girls were more likely to talk to their mothers about sex. Some talk to brothers and sisters but the fear of being laughed at meant that siblings are not a major source of advice.

The S5 girls in particular stressed that often parents were embarrassed to talk about the subject.

My mum gets embarrassed just talking about it and that makes you feel embarrassed.

My sister got pregnant and my mum just said don't you do nothing like that.

My mum doesn't even talk about it. S5 Girls

Many of the S5 girls felt that talking about sex had been a taboo subject in their home for so long that when parents did raise the subject it made them (often both parents and pupils) feel very uncomfortable. The S5 boys said that while their parents were potential sources of information and advice they were usually 'old fashioned' in their views and usually told them that they should wait until they were older before becoming sexually active. The boys, however, did not believe they should wait. In the group interviews the S5 boys also commented on the usefulness of womens' magazine problem and advice pages.

Magazines and television were used as a source of information on sex by pupils. S1 girls indicated that a wide range of magazine articles on sex were read and discussed with friends. The problem and advice pages of magazines such as *Just Seventeen*, *More* and *Sugar* were mentioned by girls as favourite sources of information. Other media are important influences on decision making on whether or not to have sex and about contraception, safer sex, pregnancy and relationships. Programmes such as *Scottish Women* cover salient issues and allow discussion on the topics. This enables pupils hear a number of views on a subject and think about how the issues related to them. One girl said a teenage version would be welcome. The girls were a critical audience and were aware that the content of much T.V. was fictional and they felt unbiased information was needed. Pupils enjoyed soap opera style programmes but thought them as overly dramatic and focusing on relationships. The girls felt that reality was often less dramatic and often more frustrating.

Pupils' comparisons of the different programmes

Few S5 pupils remembered much about the previous years sexual health programme but they still remembered in a very positive way the first, sexual health programme taught by the health workers. One explanation for this is that the Phase 2 programme had a large focus on relationships which pupils might not directly associate with sexual health when responding to our questions. Therefore, when these pupils were asked to recall sexual health programmes and make comparisons, the Phase 1 programme might have been perceived as more directly associated with sexual health.

■ Further insights on pupils' sexual health needs and perceptions

Group interviews were used to explore in more detail pupils' perceptions and issues they saw as important. This method enabled the evaluation to illuminate more complex issues such as what affects pupils decision-making. We look now at of the pupils' preferences in relation to learning and teaching and what influences the decisions they make concerning sexual health.

How would pupils prefer to learn about sex in school?

The issue of whether sexual health should be taught in mixed sex groups emerged with more boys than girls in the group interviews saying mixed groups would be a good idea because they could hear what the girls had to say on the topics and the course included learning about the opposite sex and relationships. The girls were notably less enthusiastic about the idea of mixed sex groups. They generally saw the boys as immature and likely to break confidentiality rules concerning any personal topics which were raised, as the following comment illustrates.

> *The boys are dirty minded ... They'll all tell their pals then you get slagged off by the whole class*
>
> S1 Girl

Who should teach the course?

Boys and girls in both S1 and S5 groups agreed that the ideal person to teach a sexual health programme should be someone from outside the school with specialist knowledge, preferably young (because they feel they are more likely to empathise with the pupils) and who will assure total confidentiality.

The S5 groups felt that one of the main reasons a sexual health course should be taught by someone from outside the school was because they would not see the person on a day-to-day or long-term basis. This helped to reduce the possible embarrassment and promoted a relaxed atmosphere more conducive to discussing relevant topics.

The girls mostly wanted a young woman to teach them because "she'll be going through it". However, it is worth noting here that in the post-programme focus groups one group of S1 girls said that it was not so much a question of the sex of the teacher but, more importantly, whether the teacher would discuss the topics with them in an open and honest fashion.

All the groups interviewed felt that teachers would be more likely than health workers to get embarrassed by, or avoid, certain sexual health topics and might not be able to always ensure confidentiality. The S5 pupils claimed that these assumptions were based on their experience of the previous programme.

> *Teachers get all embarrassed when you ask them a question and they change the subject*
>
> *They don't explain anything they just say this is this and that is that and that's it*
>
> S5 Girls

One group of S1 boys stressed that whoever taught the sexual health programme, they should be well trained and that consideration should be given to a male and female teacher taking the class at the same time.

Pupils' sexual health decisions

The S1 pupils were aware that sexual health and relationship issues were important because they felt they would be involved in sex in later years, therefore it was important to learn about these topics now to prepare them for decisions they would have to make. Looking ahead, the S1 boys and girls felt that the most important decisions for them would be how to decide when to have sex. The question of when was the right time to begin a sexual relationship was an important issue for these pupils. The boys were also interested in decisions concerning condom use. The girls were more likely to talk about relationship decisions such as knowing when it was right to go out with someone and whether they were going to be long-term partners.

The views of S1 pupils were echoed in the focus groups with S5 pupils. The decision on whether to have sex and to use condoms to avoid STDs and pregnancy was the main topic raised when discussing decision making. According to the discussions in the focus groups this seemed to be a more salient issue for the S5 pupils compared to those in S1. One S5 girl focus group in particular stressed that information on sex and the possible consequences of sexual activity was especially important to them given that most in the group claimed to be sexually active. Three S5 girls were especially concerned about decisions on whether to have a baby or consider abortion or adoption. It was not clear whether this interest in such decisions was based on these pupils' actual situation or whether it was general curiosity.

What shapes pupils' decisions?

For S1 pupils the issue of STDs was an important factor which would affect their decisions when the time came for them to become sexually active. Wanting to avoid diseases including HIV/AIDS would, they said, affect their decision to use a condom. The girls also stressed that concern over getting pregnant would affect their decisions concerning sex including whether to have sex and to use contraception. Girls were also concerned about decisions relating to relationships such as whether to go out with a boy and when to invest or commit more to a relationship to make it 'serious'. The effects of alcohol on decision making concerning sex was mentioned by the girls who seemed aware of the potential of drink to alter a person's mood and so affect decisions concerning relationships and sexual behaviour.

Factors affecting the S5 pupils' decision making were similar to those highlighted by S1 but it was clear from the group interviews that, whereas most of the S1 pupils were projecting to a later time, the S5 pupils were far more likely to be facing such decisions currently. The girls, like those in S1 talked about the influence of relationships and their feelings for their partner on their sexual decisions. S5 boys and girls both raised the issue of a partner's sexual history and reputation and how this would affect whether they would have sex and whether they would use a condom. Here was an insight that the perceived sexual activity of a partner or potential partner was linked to perceptions about the likelihood of their having STDs. This, in turn, then influenced some pupils' views on whether it was possible to risk not using condoms.

The influence of others on pupils' decision making was said to be an important but not overwhelming factor. The views and opinions of friends, and especially older pupils in the school plays a part in shaping the views and decisions of S1 pupils. Sometimes family members such as brothers sisters and parents also affect the S1 pupils' views and decisions. S1 girls often seek the advice of trusted peers on what to do in relationship situations but would also be willing to approach their mothers about body change issues. From the group interviews it seems that older teenagers are particularly important source of information and shapers of opinion on sexual health. This could have implications for future efforts to provide sexual health education in this and other schools.

Some of the S5 boys claimed that older brothers and sisters could influence their decisions and that they sometimes followed their example. Conflicting messages came from the group interviews about the role of friends in decision making. In general, pupils were very careful to seek advice from friends as confiding in some people had led to confidential matters being spread around their class. While peers were a source of information and advice and could influence sexual health decisions, most of the pupils claimed that they would be confident to assess the views and information offered by

others (and the media) and make up their own minds. This view seemed to be more apparent in the S5 pupil groups. However, boys in one S5 group said that they felt they did sometimes conform to the views of some friends and engage in activities that they were less than happy about.

The Health Board perspective

Before the programme began the Health Board provided information and their views on: the preparation; planning and training involved for the current sexual health programme; communication between the school and Health Board and whether or not previous experience of teaching the course and evaluation findings had shaped the current course.

Planning the programme

During the summer of 1995 the Health Board and school discussed the nature of the programme intended for the school year 1995/96. The teachers who were involved in the programme actively shaped the curriculum and the Health Board designed the programme to take on board the teachers' comments and earlier evaluation findings. The main revisions were:

- The programme's duration was altered to five rather than the four weeks of the previous year.
- The section on assertiveness for S4 was altered to make the concept more accessible to the pupils. There had been some concern from teachers that, given the relatively short amount of time on the programme, the goal of developing assertiveness was too ambitious because of its complex nature. It was agreed to concentrate first on reducing aggressiveness.

The health worker co-ordinating the development of the 1995/96 programme was generally happy with the new design as it still corresponded to the ethos of the overall approach. Ideally, other topics could have appeared in the curriculum, however, the limited time available for the programme and the fact that certain topics were quite complex meant that these topics would have to wait. The topics and issues which could be considered for future sexual health programmes in the school were seen as :

- Sexuality. Detailed coverage of this topic was relevant to pupils' needs and could be provided in the S5 curriculum.
- The issue of sex as a positive and pleasurable activity. Usually, sexual health curricula concentrate on the negative aspects of sex such as STDs and unwanted pregnancies. The overall tone of such curricula can, therefore, appear gloomy and ominous. This could be counterbalanced by discussing sex as a very positive life enhancing activity.
- Sexual violence.
- The relationship of value systems and religion with sexual health.
- Male issues such as violence/aggressiveness and macho self-image.
- Assertiveness and self-determination. This topic is being touched on but requires more long-term work to address the complex issues and concepts.
- Developing long-term perceptions of health with pupils. The health worker saw this 'foresight' as an essential addition to any assertiveness and knowledge based input in sexual health programmes as it allows young people to better grasp the risks involved in certain behaviours.

The Health Board felt that in the pilot school the teachers would be generally open minded about incorporating new topics when there was time and it was seen as appropriate.

The Health Board saw the communication between them and the school as very effective. Schools varied in their commitment to the health of their pupils but this pilot school's PSE department was considered 'exceptional' in terms of its ethos and approach to pupils and staff commitment.

Training for teachers

Training for teachers involved with the new programme was seen by the trainers as adequate since the teachers felt confident about dealing with the material and teaching on the programme. Meetings with the teachers every month provided continuing support and addressed any emerging needs or queries. Before the programme started, the teachers and health worker had four, one hour sessions where the materials were scrutinised and discussed. This process also acted as a mechanism for fine-tuning the content to match the comments of the teachers.

The training highlighted the fact that some teachers were more likely to be comfortable with, and skilled at triggering, discussion on sexual health and developing it with a group. Health workers specialised in teaching health topics which include sensitive issues and so develop ways of building rapport and promoting discussion on sexual health. Given enough experience and training the Health Board felt that most teachers could promote their skills in this area.

The Health Board co-ordinator felt that it was important that anyone teaching sexual health should be able to discuss relevant topics, be able to draw on a range of teaching techniques and must avoid being judgmental. Adults including some teachers might not always be aware of the every day reality and lifestyle of young people and this could make it difficult to develop discussion triggers and develop rapport. This was thought to be less applicable to PSE teachers, nevertheless, an important part of the training supported teachers in discussing sexual health topics with pupils. Training included developing skills to responding to pupils' questions and developing them into useful discussion. Developing teachers' skills to use role-play in sexual health programmes was another area of training. Role-play was seen by the Health Board as a potentially effective way of getting young people to think about the issues covered in the programme.

The Health Board co-ordinator noted that where discussion approaches, role play and learner-centred approaches were used, they would work best where teachers and the culture of the school were already comfortable with these approaches. Ideally, learner-centred approaches enable pupils to have more control over the learning process. This approach helps programmes to better reflect the needs of pupils. A learner-centred approach might not always be easy for schools to adopt given external pressures on the curriculum and learning approaches. However, appropriate training and a willingness on behalf of schools to explore new approaches which are geared at meeting pupils' needs are conducive to adopting these approaches. The pilot school was seen by the Health Board co-ordinator as working toward innovative and pupil-centred approaches.

The views of teachers prior to the programme

The teachers were asked to complete a questionnaire prior to the start of the sexual health programme. The questions covered their expectations and views about the

teaching methods to be used on the programme, their training for the new programme, the most appropriate topics for certain age groups and wider issues concerning sexual health education in their school. In addition to closed questions the questionnaire allowed teachers to provide much of the information in the form of open-ended questions.

Teachers expectations of the new programme

Of the eight teachers who responded, seven felt very comfortable with the proposed teaching approach to be used on the programme and had no worries about teaching the programme without input from health workers.

Teachers felt their experience of teaching sexual health on the previous course and their training had provided them with skills they saw as necessary to deliver the course. Being able to work in close collaboration with the Health Board in designing the programme seemed to be reassuring and promote teachers' confidence in the programme.

Overall, teachers were agreed that the new programme would work well. The perceived advantages of the teacher-only approach centred around minimising disruption and emphasising continuity in terms of the person teaching the content. Improved discipline was also cited by individual teachers. Teachers felt that the possible disadvantages of the new approach were in not having the subject expertise of the health workers available to answer some of the pupil questions. Two teachers said that health workers also provided a "fresh face" for pupils which could increase their enthusiasm and health workers were also a source of new ideas.

The programme content was seen appropriate for the various pupil year groups and reflected the views of teachers made at the design stage. The emphasis of the content was on providing both knowledge on sexual health as well as skills for pupils to deal with situations. Also, the increased levels of teacher confidence gained from their involvement in the previous programme was expected to enhance the current programme. Only two teachers had minor reservations: one had not taught the programme before and did not know what to expect, the other was generally comfortable with the content but noted that some of the values in the programme contrasted with their own.

Teachers' views on their training

While the teachers were more confident as a consequence of the training, they made the following suggestions for improvement:

- More practical demonstrations of the teaching methods by health workers.
- Having more time to explore the issues that could arise in the classroom.
- More in-service devoted to teaching sexual health.
- Training should take place earlier and well before the start of the programme, and could include regular refresher sessions and more opportunities to raise and discuss any problems and concerns.

In addition to these training needs the teachers felt that further support could be informed by on-going evaluation which would up-date the programme and highlight training needs.

Teachers' perceptions of pupils' sexual health needs

The teachers were asked to consider a closed question and select which topics certain pupil year groups should receive. Their responses on the content to be taught to the different pupil year groups were very similar to evaluation findings and are shown in Table 6.

Table 6: Pre-programme: Teachers perceptions of appropriate topics for pupil age groups

Topic	S1	S2	S3	S4	S5
Body image	8	6	4	2	1
Peer pressure	7	6	8	5	4
Sexually transmitted diseases	2	1	8	6	6
Sexuality	3	2	6	7	7
Introduction to contraception	3	3	6	4	4
Decision making	5	6	7	6	6
Puberty	8	5	3	0	0
Assertiveness	2	2	6	6	6
Feelings and relationships	4	3	7	6	8

Teachers stated that the course content emphasis should be on body changes for S1 and S2 with topics such as STDs, contraception, feelings and relationships, and sexuality being more appropriate from S3 onwards. Addressing peer pressure is important for S1 through to S4 but assertiveness which overlaps with this topic is seen as being more suitable for S3 onwards.

The pupil data highlighted that one topic older girls wanted to learn more about was pregnancy and related issues. Unfortunately this was not included in the question put to teachers and described above. However in the teacher group interviews, teachers were aware that pregnancy was an important topic for the overall programme to address and saw this subject as being mainly relevant for S3 and older pupils.

Of the eight teachers, four reported that they had been able to find out about the pupils' sexual health needs prior to the programme by talking to pupils, using suggestion boxes and taking account of media information, previous evaluation findings and literature from the Health Board.

Teachers' views on wider issues affecting sexual health education

Teachers suggested that the main issues facing sexual health education in schools fell into two broad categories: the content of programmes; planning the programme and methods of working with young people.

Content

- Ensuring the sexual health curriculum reflects young peoples' needs and addresses pregnancy, contraception, STDs and feelings and relationships.
- Relating emotion and relationship issues to the physical aspects of sexual health.

Planning and methods

- Continuing and developing collaboration with the local Health Board.
- Exploring ways of providing sexual health education to classes where the range of sexual maturity and experience is diverse.

- Developing young peoples' awareness of their own sexual health and how to stay healthy through empowering them to make healthy choices. This includes focusing on skills which allow pupils to make safe and healthy decisions.
- Developing effective teaching methods for sexual health education.
- Understanding pupils' environment when designing and providing sexual health education.

The other most striking point to emerge from their comments was the enthusiasm for teaching on the course and that any initial misgivings about their involvement had gone. The teachers also stressed the extremely important input and effort of the Health Board staff during their work with the school and said that their work had greatly contributed to the incorporation of the programme into the school curriculum.

A potentially contentious issue was raised by one teacher who had noticed that some S5 pupils had expressed an interest in learning more about improving their "sexual techniques". This teacher felt that the PSE and other teachers were not necessarily the best people to teach this topic and was uncertain that the school was the most appropriate or conducive environment for teaching such a topic. One teacher expressed very clearly that role of sexual health in schools and the approach teachers should take.

> *I am of the opinion that education on sexual health should be a prominent feature of all personal and social education programmes in schools. I see myself as a provider of information on sexual health and not as an arbiter or maker of moral judgements.*
>
> PSE teacher

Conclusion

Overall, pupils were looking forward to the programme and wanted to learn about sexual health in general. As one might expect S1 and S2 pupils were more interested in learning about body changes and puberty with STDs, safer sex and contraception being of interest to S3 and older pupils. S5 pupils, particularly the girls were also interested pregnancy issues.

Pupils had few anxieties about the programme. A small number were anxious about the possibility that they might look foolish to their peers if they demonstrated a lack of knowledge in the class. Girls were more likely than boys to want the teaching to take place in single sex classes because boys were seen as immature, could not be trusted to maintain confidentiality and hindered learning. S5 pupils were concerned about being taught by a teacher who knew them and claimed both they and their teacher would be too embarrassed to talk about certain topics. Providers who were from outside the school, who were young and of the same sex as the group being taught were seen as the ideal teacher by the S5 pupils. Teachers sympathised with this view and were aware that S5 pupils in particular were sometimes uneasy about discussing some sexual health topics in a class with their teacher.

Despite the reservations S5 pupils had about discussing some subjects with teachers, they and the majority of other pupils still felt that the school provided the most accurate and useful sexual health information and advice compared to other sources such as friends and parents. Friends were a common source of information and an important influence on decisions concerning sexual health. However, the pupils were critical consumers of information from friends and stressed that, in most cases, they were able to make their own choices.

The teachers were very comfortable with the content and approach proposed for this sexual health programme and fully supported the ethos of the programme. Their confidence was seen as arising from the quality of training and their involvement in the previous sexual health programme. While teachers praised the quality and usefulness of their training they would have liked more of it and have it provided well before the programme was to be taught.

The benefits of adopting a teacher delivered approach for this programme were seen as emphasising continuity in terms of the person teaching the programme and providing an opportunity for better rapport between pupils and teachers. Possible disadvantages of this approach could be that external specialist teachers such as health promotion staff were likely to have more subject expertise and some pupils would discuss more openly certain topics with these people. Before the programme started some teachers questioned whether they and the school were suitable providers for certain, specific topics of sexual health. For example, some S4 and S5 pupils had in the previous course wanted advice of sexual techniques. These teachers were unsure whether school was the most conducive place for learning about these topics.

There was consensus among teachers that the Health Board had been extremely helpful and effective in assisting them to design and implement the programme and that the school should maintain close links with the Health Board for further training and advice.

6 Post-programme evaluation findings

The post-programme data gathering from pupils and teachers revealed general satisfaction with the programme in terms of its content and approach but some older pupils did have critical comments which were already being recognised by their teachers. We look now in more detail at the post-programme findings and begin with what pupils' views on their programme.

The views of pupils

Pupil satisfaction with the programme

In all, ninety nine pupils completed the post course questionnaire and we look first at their general satisfaction with the programme. Pupils were asked to rate their happiness with the course on a four point scale (very happy, quite happy, quite unhappy, very unhappy). Seventy eight out of ninety eight pupils (80%) completing the questionnaire reported that they were either happy or very happy with the course that they had received.

Looking at course satisfaction by sex, boys were more likely than girls to report satisfaction. Thirty eight out of forty boys reported being either quite happy or very happy with the course while forty out of fifty eight girls expressed such satisfaction. Table 7 shows those pupils who recorded either being very satisfied or quite satisfied with the course by year and sex.

Table 7: Post-programme: pupils reporting being either very happy or quite happy with course

Year	Males	Females
1st	12 from 12	12 from 12
2nd	7 from 7	14 from 14
3rd	8 from 8	8 from 9
4th	5 from 6	6 from 11
5th	6 from 7	1 from 12

- All pupils in S1 and S2 reported a degree of satisfaction with the course.
- The majority of the dissatisfaction arises from girls in S4 and especially S5.

In the S1 and S5 group interviews, S1 pupils reported that were more likely be satisfied with the programme than those in S5. S1 pupils appreciated the relevant content, especially puberty and physical development which they found interesting. Initial concepts on safe sex were also valued by S1 pupils. The demystifying of sexual health issues with factual information had, they claimed, promoted their confidence and reduced levels of anxiety. S1 boys were very curious about aspects of contraception and safer sex and they would have appreciated more coverage of condoms.

The S1 girls were positive in most of their comments about the value of the programme although they were more vocal than the boys in identifying topics that could have been looked at in more detail, such as the physical development of boys. One group

of S1 girls reported that discussing aspects of the content had sometimes been a little awkward. These pupils and their teacher seemed reticent to discuss topics such as condoms, having sex, and abortions.

> *We asked her questions and she wouldn't tell us she said you'll know when you are older...She just got a riddi. (embarrassed)*
>
> *I asked her about getting pregnant and she said it was in the video but it wasn't in the video because I asked her.*
>
> *We asked her about the pill and she wouldn't tell me.* S1 girls

Nevertheless, the majority of S1 pupils were generally satisfied with their programme. S5 pupils, particularly the girls, were more critical of the programme. The S5 girls interviewed in groups were more critical of the programme than their male peers and gave specific details of what they thought was wrong with the programme. This list provided by S5 girls should be viewed in the context of overall pupil satisfaction with the programme:

- The topics (eg HIV, Contraception) had not really progressed from those they received in S3.
- The programme contained little on teenage pregnancy and related issues and options. This topic was the S5 girls most important topic they wanted information on.
- There should have been a lot more discussion and fewer self-completion tasks.
- The S5 class project concentrated more on their imparting advice to younger pupils rather than having their own sexual health needs met. The relevance and aim of the S5 class project had not been made clear at the outset. The teacher had 'censored' what advice and topics S5 pupils could cover in their leaflets designed as part of their project which were actually based on younger pupils' reported needs.

A book used to inform pupils about teenage sexual health issues was criticised by the S5 girls in their group interviews as being for a younger age group and the experiences and scenarios covered had long since been encountered and dealt with by these girls. The S5 girls commented on other texts which had jargon or were 'full of complicated words' and were difficult to read.

The main reason for the S5 girls dissatisfaction was that their main topic of interest related to teenage pregnancy and options such as abortions. There was consensus that these topics were not fully addressed and the girls felt that they were inhibited from asking the teacher about these topics. These pupils said that had health workers been teaching the programme then they would have felt much more able to ask questions.

While the group interviews have provided more detailed information on the criticisms of some pupils, particularly the S5 girls, we must be careful to place these points in perspective. The overall findings of the questionnaires show that for most year groups the programme was well received and considered to be relevant and well taught. Also, the group interviews with the S1 pupils and S5 boys demonstrated that, while there were some criticisms, their overall view of the programme was a positive one.

The following sections provide more details on reasons for satisfaction and dissatisfaction with the content and approach of the programmes.

The most important topics for pupils

Pupils were asked what they thought were the most important topics that they had learned about. Most commonly, they indicated, bodily development (21 responses), safer sex and AIDS (18 responses) and contraception (14 responses). However, since the course input was tailored to each year group it is important to look at responses by year and sex. This data is presented in Table 8

Table 8: Most important topics by year and sex (frequency of responses)

Year	Males		Females	
1	Development	7	Development	9
	Safer sex/Aids	3	Pregnancy	1
			Everything	1
2	Safer sex/Aids	5	Sex general	6
	Development	2	Development	2
			Safer sex/Aids	1
			R'ships/feelings	1
3	Contraception	4	Contraception	2
	Safer sex/Aids	2	Sex general	1
	Everything	1	Development	1
4	Contraception	2	Safer sex/Aids	5
	R'ships/feelings	2	R'ships/feelings	5
	Safer sex/Aids	1		
5	Contraception	5	Sex general	1
	R'ships/feelings	1	Safer sex/Aids	1
			Contraception	1

While it is difficult to draw firm conclusions from such small numbers there are one or two tentative observations that can be made.

- Development is more frequently mentioned in the lower school and especially in the first year. The group interviews with S1 pupils highlights that pupils in this age group are curious and often anxious about their own and their peers' bodily development. It may also be that because physical development is emphasised in the content for this age group, pupils will reflect this emphasis when reporting what is the most important topic for them.
- Contraception is mentioned only from third year, most commonly reported by boys. While this again might be a reflection of the course content it does not fully explain the male/female difference where boys seem somewhat more interested in this topic. This finding adds some weight to the decision to design the course to focus on contraception in detail from S3.

Interestingly, one of the S5 girl groups involved in the group interviews said that one of the most important things they had learned from the programme was not to blindly trust boys when it came to sex and relationships. This issue was not an aim of the formal programme curriculum. From one mixed session during the programme, the boys had been questioned by the girls using a questionnaire about their views and attitudes relating to the girls concerns, including pregnancy. The result of this session was the shattering of any rose-tinted perceptions the girls might have had about boys. The apparently

uncaring and macho replies (whether actually reflecting the boys' feelings or whether they were more of a superficial group posturing) certainly annoyed the girls.

Why were topics important for pupils?

Most of the pupils who elaborated on why the topics were important to them felt it was necessary to know about these topics generally to help them as they grew and formed relationships. Boys and girls gave the same types of reasons for why certain topics were important.

Those who stressed physical development as the most important topic said that it was something they just wanted to know about generally, but also it helped satisfy their curiosity about the biology of the opposite sex. Those pupils who said contraception was the most important topic for them said this was because they had found out more about how to use the various methods. Those who particularly stressed the importance of learning about safer sex said that it was important to them because they wanted to be sure they knew how to avoid STDs including HIV/AIDS.

Topics pupils would have liked to have learned more about

The questionnaire asked pupils if there were any topics that they would have liked to know more about. Results for those who provided responses to this question are presented by year and sex in Table 9.

Table 9: Post-programme: topics for further coverage (frequency of responses) by year and sex

Year	Males		Females	
1	Know enough already	10	Know enough already	5
	Sex general	1	Safer sex/Aids	2
	Periods/puberty	1	Sex general	2
			Periods/puberty	2
2	Safer sex/Aids	7	Know enough already	6
			Teenage pregnancy	1
			R'ships/feelings	1
3	Know enough already	6	Know enough already	5
			Puberty/periods	1
			R'ships/feelings	1
4	Safer sex/Aids	3	Know enough already	4
	Sex general	2	Safer sex/Aids	1
	Know enough already	1	Teenage pregnancy	1
			Sex general	1
5	Know enough already	4	Teenage pregnancy	9
	Safer sex/Aids	1	Safer sex/Aids	1
	Sexual techniques	1		

Again it is difficult to draw firm conclusions when dealing with such small numbers however, there are one or two observations that can be made.

- Across the year groups a proportion of the pupils express the feeling that they 'know enough already'. This seems to mean that pupils feel they have learned enough facts and skills for this year and cannot think what else they would want to cover rather than they know everything and further sex education would be redundant.

- Whilst teenage pregnancy is mentioned only twice from S1 to S4, once by a girl in S2 and once by a girl in S4, it is mentioned by a three quarters of the S5 girls group.

The group interviews with S5 girls demonstrate the concern of S5 girls with teenage pregnancy. When probed about their interest in pregnancies and related issues, the girls said it was important to know about these topics because many teenagers in their community became pregnant. They felt that this was because young people lacked knowledge about contraception and also did not appreciate the full implications of being pregnant.

> *It's not just because they don't know enough its really complicated...They don't know the consequences of having a baby. Or you think if its only one time well it'll not be this time I get pregnant. Then most of the time if the boys don't have a condom they'll say you won't get pregnant.*
>
> S5 Girls

What did pupils think about their teachers?

Pupils were asked to rate on a four point scale (very good, good, poor, very poor) how well they thought the teacher had taught the course. Sixty seven out of ninety five responding to this question (71%) said that the teacher was either good or very good. However, there was some variation in the responses from males and females and across the year groups. Table 10 shows the numbers of pupils who indicated that the teacher was either good, or very good, in teaching the course.

Table 10: Post-programme: satisfaction with teacher by sex and year

Year	Males	Females
S1	11 from 12	11 from 11
S2	7 from 7	13 from 13
S3	7 from 8	7 from 9
S4	4 from 6	5 from 11
S5	3 from 6	2 from 12

The main points to highlight from these findings are:

- All responding pupils in S1 and S2 reported that they thought the teacher was either very good or good.
- The majority of dissatisfaction with the teacher was recorded by S4 and S5, most pronounced in S4 girls and especially S5 girls.

Again the findings from the group interviews with S1 and S5 pupils allow us to explore in more detail some of the quantitative findings. The teachers were seen by the S1 boys as being generally approachable about the topics covered and were better than they had expected. The teachers were perceived as trying to be helpful. However, in addition to the time factor affecting the extent of discussion, the pupils felt that, occasionally, the teacher would not follow up a question or was elusive on certain points. One such point concerned details of contraception.

S5 boys were mixed in their views on the way the programme was taught. The two S5 boys groups thought that the teachers were sometimes too strict and insisted on using formal language. This meant that some boys felt limited in expressing themselves. The training for teachers and the initial part of the programme emphasises the importance of agreeing on, and using appropriate and acceptable language. Given that this is still a

relatively new programme and language is often a tricky issue for staff who teach sexual health education this problem might be expected at this stage. Also, bringing teachers and pupils together in their use and acceptance of language can be addressed by further training.

Some of the S1 girls repeated the points made about having to discuss sexual health with a teacher and how this could be inhibiting. In one of the one group of S1 girls peer education was raised as a possible method of teaching the programme or parts of it. The girls thought topics could be taught by 'responsible lassies...one of the sixth years...it wouldn't be as embarrassing'. Others on the group were less sure because they were worried about the issue of confidentiality and how well informed such an educator would be. For these reasons health workers were again mentioned as an ideal teacher for this type of programme. The S5 girls echoed and emphasised the points made by S1 girls concerning the difficulty of discussing some important topics with teachers.

The teaching styles all pupils admired and thought conducive to sexual health teaching included those which treated them with respect, responded to their questions honestly and were not evasive. It seems that when teachers did not explain why they would not discuss certain topics in detail this was a major source of frustration and damaged teachers' standing with that class. One group of S1 girls claimed that their friends who had been taught by other teachers seemed to have received more information. This apparent discrepancy in the level of information imparted and types of questions answered made this group unhappy especially because they now seemed ignorant compared with their peers.

What did pupils think about the teaching about sexual health?

The programme used a range of teaching activities and materials. The content was delivered by PSE teachers who used video, some discussion, self-completion and reading material, and quizzes. No role play was used but the S5 work involved a project. The programme, as in previous years used mainly single sex classes but one session, a discussion, was mixed sex. The group interviews used in the evaluation illuminated pupils' perceptions on these teaching activities.

There was an exercise where fruit was used to demonstrate genitalia and development. This was seen by one class of S1 boys as unhelpful and could have been done better with cut out shapes and diagrams. There was consensus among the two S1 boy and girl groups that the programme had undue reliance on worksheets and this criticism was exacerbated by the fact that such self completion tasks took up valuable discussion time. The lack of time for discussion was the most serious criticism the boys had.

There was little enthusiasm among the S1 boys for the video used on the programme. This used cartoon style imagery and focused mainly on physical development. It was felt that this video should have used better, more realistic imagery and should have covered other aspects of the programme such as safer sex. We can speculate that some boys were critical of the video because it used a cartoon style and, as group, these boys might have wanted to be seen as being 'too old to watch cartoons'.

Some S1 boys in the group interviews said that mixed sex classes would be a good idea because 'you can learn what girls think when you speak to them in the same class'. One group of S1 boys claimed that they had been asked if they wanted to be in a mixed class. They replied yes but this had not happened.

The S1 girls were split over whether there should be mixed classes. Those against the idea said that boys were too immature, those in favour of the idea thought that it would

be a way of finding out more about boys' development. The S5 girls were also divided over the pros and cons of mixed classes, some thought they were old enough to relate to boys about relationship issues and were interested in boys' opinions. Others thought the boys would not be interested in the things the girls wanted to learn about and would be too immature. Generally, boys of all ages seemed more enthusiastic for mixed sex classes than the girls.

The most critical comments about the teaching approaches on the programme came from the S5 girls. They were expecting a similar course to the previous ones but were very disappointed in the content and methods used. Some of these girls had spent their time making up a poster about a health club which they thought did not appear to have had much relevance to sexual health. The girls had also been given a book to read which covered teenage problems but felt it was geared towards a younger age group.

> *It wasn't the same as we done the last time we didn't get taught anything we just made posters...or questionnaires and make them up to give to other classes...It wasn't like getting a sexual health course. It was a load of rubbish about a health club it was a pure waste of time.*
>
> *We read a book as well for four weeks we did the same thing - girl talk...It was stupid things like I've never kissed a boy and I'm scared and all that* S5 Girls

These girls felt previous programmes had been much better as they had been given various activities

> *We just spent our time doing nothing...I thought it would have been like the last time when did it learning new things but it wasn't it was just questionnaires...Last time it was much better because we got games and we got all different things.* S5 Girls

The girls were also given a choice of books covering different topics but some found them difficult to understand.

> *We didn't get nothing. We were just told to make a poster and read books...They were full of complicated words* S5 Girls

The comment that more time should have been given for discussion emerged as a major concern in all of the group interviews. Pupils seem anxious to use the sexual health lesson time profitably. However, even if more discussion time was built into the programme it is uncertain whether it would be fully utilised in the case of the S4 and S5 year groups, especially in the girl groups. For example, S5 girls said that they could not 'open up to teachers' and that the teachers were inhibited in talking to them about topics they really wanted to know about. These topics were mainly pregnancy and related options.

It is clear that it is the S4 and S5 groups, particularly the girls, who are the most critical of the course. This pattern runs across the questionnaire data and is mirrored and expanded upon in the information provided by the S5 group interviews. The criticisms, especially when portrayed in the quotes of S5 pupils are quite powerful and emotive and while they should be taken seriously, we should also keep these points in perspective. We must remember that the other year groups reported general satisfaction with the content of the course and the way it was taught.

Also, it is difficult to assess whether a particular year group has a higher proportion of pupils who are dissatisfied with teaching in general and are more cynical than other year groups and comparable pupils researched in earlier evaluations. One would have to monitor the views of S5 pupils concerning the programme over subsequent years to better assess whether the criticisms raised are particularly due to the programme design

and teaching or whether the criticisms are more a product of the overall perceptions of teaching by 1995/96 S5 pupils.

Did pupils consider the content useful?

Pupils were asked to indicate on a four point scale (very useful, quite useful, of little use, of no use) if they thought that what they had learned from the programme would be useful to them. Seventy one of the ninety five responding to this question (75%) agreed that the course was either quite useful or very useful. The content relating to the development of their bodies and the other sex were particularly valued as was that which covered STDs. Table 11 contains the frequency of pupils who stated that the programme was quite useful or very useful.

Table 11: Numbers of pupils reporting the programme as useful by sex and year

Year	Males	Females
1st	10 from 13	8 from 11
2nd	7 from 7	10 from 12
3rd	8 from 8	8 from 9
4th	3 from 6	7 from 11
5th	6 from 7	1 from 11

We can see from Table 11 that the majority of dissatisfaction with the course in terms of its usefulness was reported by S4 boys, S4 girls and more markedly by S5 girls. This adds to the emerging pattern in the data that the programme had difficulty in engaging the interest and meeting the needs of S4 and S5 pupils, particularly the girls. The teachers were aware of this as the programme finished and suggested that the content would have to be reviewed (this mainly referred to omitting or revising the project part of the fifth year programme). Like the S4 and S5 pupils, the teachers were also aware that one of the main problems was that older pupils were often reticent about discussing many sexual health topics with their teachers. This could limit what these pupils might learn from the programme and affect its overall usefulness.

It is interesting that from this evaluation and the two previous ones, pupils can be seen to become more reluctant to talk to older adults (teachers and their parents) about sexual health topics and issues as they reach S3/S4. Pupils from S4 onwards seem to be far more at ease when discussing these topics with younger adults, especially when they are relative strangers and have relevant expertise: the characteristics of the health workers. The reluctance to talk to parents and teachers could be because both are often seen by young people as having a disciplinary role as well as a pastoral role. This could exacerbate the age difference which makes sharing common frames of reference difficult.

Sexual health decisions: did the course seem to help?

After the programme the group interviews with S1 and S5 pupils focused, among other things, on the types of sexual health decisions they faced or were likely to face. The main sexual health decisions mentioned by S1 pupils were when and whether to have sex with a partner (linked to this were issues concerning the legal age limit) and practising safer sex when the time for having sex came. Ten of the 27 S1 pupils included in the focus groups said they had not decided about the use of condoms. Eight of these pupils said that they were now aware of the importance of condoms but would risk not using one because it was supposed to 'feel better without one'. There are two interpretations for

this somewhat alarming outlook. Firstly, these were S1 boys who were not sexually active and one might speculate that when these boys are faced with an actual situation when intercourse is likely their outlook might be affected by the real issues of STDs and unwanted pregnancy. This view is corroborated by health workers who report that younger boys will often sensationalise their views in groups and this will not necessarily reflect what they will do in a real situation. The second possibility is that this unsafe outlook actually reflects their perceptions and risk-assessment and this would highlight the dissonance between knowledge and behaviour and the related difficulty facing health education when attempting to provide health promotion and impact on behaviour.

One boy was interested in deciding about his sexual orientation and wanted advice on this. This was an impressive display of self confidence for an S1 pupil to speak out in front of his peers about this issue. One would imagine that the often overtly macho atmosphere in male peer groups would have inhibited this pupils from raising the point. Perhaps, even more interesting was that fact that none of his peers even queried his point.

In one of the two S1 group interviews with girls, to participants were concerned about boyfriends who might leave them if they did not have sex. These girls had older boyfriends and were worried about the fact these boys were 'ready to have sex' and this could influence their decision making. This topic was seen as important by the other girls in this group and it had been discussed at length by them to try and find an appropriate response. The girls seemed to have supportive peer groups where advice and opinions were shared on such topics.

Peer-based information and youth magazines was said to be as influential, and sometimes more so, compared to the school's current sexual health programme. These girls claimed that sexual intercourse could and did occasionally happen among their age group but was more common within the next couple of years. They were anxious that, for their age group, the current course did not provide any advice on related decisions such as avoiding pregnancy and especially where to go for unbiased, non-judgmental advice.

The S5 sexual health decisions and the impact of the course reflected the physical and sometimes emotional maturity of this age group. The S5 boys mentioned the decision on whether to have sex was their most important sexual health decision. Their decision making was shaped by the concern of STDs, getting a partner pregnant and the related issue of the availability of condoms. It is somewhat reassuring that there was no repetition of the view point of some of the S1 boys who said they would risk unprotected sex. The S5 boys seemed aware of the dangers and said that the programme and those provides in previous years had given them clear factual information on the use of condoms and their importance.

There were some in the two S5 boy groups who said the availability of condoms would shape their decisions along with other factors which were possible influences. These were; being at a party where you had privacy, when you had consumed alcohol and if friends encouraged you. The boys claimed that if the chance of having sex with a partner arose they would be very unlikely to let it pass. Again, in a group context, perhaps the boys were unlikely to say anything else. However, their points reinforce the importance of education and advice on safer sex and contraception for this age group.

Relationship decisions figured in the S5 boys' discussions, especially how one decided whether to ask a girl for a date. The boys said there was nothing on the course which helped them approach girls and deal with or enhance relationships with girls. The boys'

view of the supportive role they could play in a relationship was quite basic and actually reflected the boys' own interests. For example, boys saw being supportive in terms of encouraging and reassuring a partner that sex would be fine and enjoyable.

From the discussion in the focus groups it was clear that some of the S5 girls were having sexual intercourse and others were likely to do so soon. They said that they were well aware of the importance of condoms and that this and other courses as well as the media had made this point clear. However, the main problem for these pupils was the availability of condoms. Most of the S5 girls said that they did not know where to get condoms and related advice. Girls usually relied on their male partners to supply condoms and were often too embarrassed to buy them from chemists.

Some S5 girls had queried a teacher on why condoms were not available in schools and it was explained that where such schemes had been tried most had to be stopped because of parental opposition. The pupils understood this and were aware that if condoms were placed in the general toilets younger pupils would just play about with them. However their solution was to place them in sixth year common rooms.

Another major decision the S1 and mainly the S5 girls thought they could face in the future was if they got pregnant what would they do? Having an abortion or keeping a baby and the related consequences of options were areas these pupils felt were not being addressed. Even though these decisions were not ones these pupils hoped they were going to have to take imminently they were still very concerned to know what choices they might have.

The views and opinions of friends seemed particularly important in shaping the decisions of the S5 girls. How they were perceived by peers was an important influence. Sexual activity and even becoming a parent seemed acceptable in their social networks if the girl had been going out with her partner for some time. However, if the girl had 'casual' sex and/or became pregnant from a 'one night stand' she was likely to be shunned by her peers.

Advice and support on how to make sound relationship decisions was another important area for S5 girls and one which they thought a sexual health programme could address. They suggested the content could look at real life situations to explore relationship issues such as how to decide whether a boy could be trusted. The programme content, in theory, aimed to address relationship issues but the S5 girls felt more could have been done to make it relevant to their lives.

The S5 girls in the group interviews claimed that many of them were sexually active and none of the girls in one group felt they could ask advice from teachers because 'you'd get a lecture, you wouldn't get help'. Therefore, they wanted advice on who to approach for advice. The need for such advice was very important as, potentially, any one of them might find themselves requiring advice on contraception or options if they became pregnant:

> *Its very important because they are hundreds of young people who get pregnant every year ... One of my pals got pregnant and she didn't know what to do or where to go to and all that for help.* S5 girl

Generally, the S5 girls were quite fatalistic about their sexual activity and on coping with related issues:

> *Now a lot of us are doing it, it's not so much of a big issue.*
>
> *We've grew up a lot - its just something you do as you grow up.* S5 girls

The second quote highlights the fact that some of the S5 girls were quite fatalistic about the role of sex in their lives and that they now see themselves as 'grown up' and adult.

Pupils' views on how the Phase 3 programme compares with Phase 2

Second to fifth year pupils were asked whether they thought the latest course was better than the one provided the year before. Answers were recorded on a four point scale (much better, a bit better, a bit worse, much worse). Out of seventy four respondents, forty said that the course was either a bit better or much better. Table 12 presents the numbers of pupils who indicated either, that the course was a bit better than the previous years or much better than the previous years, by year and sex.

Table 12: Post-programme: course better than last year by year and sex

Year	Males	Females
S2	7 from 7	12 from 13
S3	5 from 8	2 from 9
S4	2 from 6	7 from 11
S5	5 from 7	1 from 12

These findings highlight that:

- Almost all S2 indicated that the course was better than the previous years.
- S4 boys, S3, S4 and S5 girls were less impressed by the 1996 course in comparison to the one provided in 1995. Based on open-ended and qualitative questions it seems that while many pupils were satisfied with the 1996 programme, the presence of health workers in previous programmes makes those programmes somewhat more satisfying to pupils. Health workers were seen as being able to respond more fully and spontaneously to pupils' needs. It must also be remembered that the 1996 programme is the first year that teachers have taught the programme on their own. From our evaluation findings over the three years of collaborative programme in this pilot school, it seems that pupils will always prefer a programme which uses external specialists. Nevertheless, it must be remembered even with this rider, most pupils said they were satisfied with the 1996 programme.

Use of material from previous courses

S2 to S5 pupils were asked whether, since the previous course, they had used any of the information or knowledge that they had gained from the course. However, pupils appeared to have difficulty in interpreting this question – for example did it refer to actively using it in a sexual situation or a more passive use such as feeling more confident about one's body? As a result, few pupils responded to this question (Eighteen pupils out of sixty eight) and fewer elaborated on how they used the information gained previously. Table 13 presents these results by year and sex.

Table 13: Post-programme: had used information since previous course by year and sex

Year	Males	Females
S2	5 from 7	4 from 12
S3	3 from 6	0 from 8
S4	3 from 6	1 from 11
S5	0 from 6	3 from 12

Those pupils who had indicated using course information were asked in what ways they had used the knowledge. Only fourteen responses were received and six of these had declined to specify how they had used the information. Responses are presented in Table 14 by year and sex.

Table 14: Post-programme: numbers of pupils claiming to have used information obtained from their programme by year and sex

Year	Males		Females	
S2	Used information in this year's course	5	Cope with puberty	1
			Not specific	3
S3	Not specific	1	N/A	
S4	To practice safe sex	2	Not specific	1
	Not specific	1		
S5	N/A		To feel more confident in relationships	3

Other help from the school or health workers

All year groups were asked what help the school or health workers could give them if they had other problems or questions about sex or sexual health. A small number of suggestions were made and are presented in Table 15.

Table 15: Post-programme: pupils suggestions on types of further support from their school or health workers by year and sex

Year	Males		Females	
S1	Other	2	Other	1
S2	–		More advice/info generally	3
			Other	5
S3	More advice/info generally	1	Longer course	1
	Info on other people to talk to	1	More advice/info generally	1
			Other	2
S4	Videos/plays	1	Info on other people to talk to	1
	More advice/info generally	1	Other	1
	Other	2		
S5	Free condoms/info leaflet	1	Free condoms/info leaflets	2
	Videos/plays	1	More advice/info generally	2
			Longer course	1
	Demonstrate condom use or other contraceptive	1	Other	1
	Info on other people to talk to	1		

It is impossible to generalise from such small numbers but these comments do reflect the views of the pupils in the group interviews. The opportunity to obtain more general sexual health advice seems to be a need which warrants further scrutiny. Older pupils, particularly girls wanted specialists outside the school to provide this advice. The S5 pupils also wanted free condoms which could be an salient issue given that both girls and boys had said that the availability of condoms was an important factor in practising contraception and safer sex. The availability of condoms was also problematic because of pupils' lack of knowledge on where they could be freely obtained and their embarrassment in asking for them from chemists.

Pupils factual knowledge

To obtain some measure of whether there had been a gain in the pupils' knowledge following the programme, a series of short statements about sex and sexual health, with correct, incorrect, and don't know, response categories were used in the pre-course questionnaire were repeated on the post course questionnaire. However, in the post-programme questionnaire, the numbers of pupils in certain year groups who completed this question were small. This means that it is impossible to attempt a meaningful analysis of any shifts in basic sexual health knowledge from this question. This highlights the need to administer this type of question to all pupils who experienced the programme, rather than one class in each year group or to track a smaller sample of individuals and ensure they complete questionnaires both before and after the programme. Future evaluation by the school or the Health Board could undertake this form of monitoring as an integral part of the on-going sexual health education programme.

Pupils thoughts on how they would design a sexual health programme

The S1 and S5 pupils involved in the group interviews were asked what their ideal sexual health programme would be like, what content would it have and how would it be taught? The following responses summarise the main points to emerge. (Responses concerning content are ordered according to year group the others are ordered on the basis of frequency).

Content

- Puberty and development (S1 boys and girls).
- Legal age of consent, i.e. reasons for age limit and implications of under age sex (S1 boys).
- Sexual orientation (S1 and S5 boys).
- Relationships. (S1 boys S5 boys and girls).
- Teenage pregnancy and related options such as abortion and sources of advice (S1-S5 girls, S5 boys).
- Contraception (S5 boys and girls).
- Less emphasis on HIV/AIDS (S5 pupils feel well informed about this and would use the time to cover other topics).

Duration

- The course should be about six weeks in duration (Most S1 and S5 pupils)

Teaching approaches

- More discussion time (Most S1 and S5 pupils).

- Less reliance on self completion materials (S5 pupils).
- Teachers answering pupil questions regardless of whether they are covered on the official curriculum (S1 and S5 pupils).
- Classes should be small (about 8 pupils in each) and consider offering an option of mixed sex classes (S5 boys and some S5 girls).
- Use of health workers to deliver aspects of programme which pupils feel they cannot talk openly to teachers about (pregnancy, contraception (mainly S1 and S5 girls).
- Videos but less animated types (S1 and S5 pupils).

The teachers' views of the programme

Following the programme, teachers were asked to complete a brief questionnaire to provide information on their general impressions of the programme and how comfortable they were with the revised design. Seven teachers (one of whom was new to the programme) returned questionnaires. The main findings presented here are organised using the major questionnaire topics.

General impressions of the programme

Overall, the teachers thought the programme had worked reasonably well and said that they were comfortable with the content and teaching approach. However, the teachers were aware that the programme had difficulties engaging the interest and meeting the needs of the S5 pupils, particularly the girls.

The teachers said that familiarity with the material, experience of teaching on the school's previous sexual health programme and their knowledge of the pupils had allowed them to deliver the programme effectively. Another factor contributing to the teachers' ability to deliver the programme was the training and detailed preparation put into the programme by the school and Health Board. The lesson plans were very clearly set out which helped teachers make the transition to teaching the programme without the health workers being present. Those teachers who had been involved in the previous collaboratively designed programmes at school said they had picked up very valuable insights about teaching sexual health which they had used on this programme.

Teachers felt that both pupils' keenness to learn, and familiarity with the methods used, contributed to the success of the programme. Teachers thought that the most effective teaching methods were:

- Brainstorming
- Small group discussion
- Game which used vegetables to illustrate genitalia (although two teachers felt this could take up a lot of time)
- Using a variety of methods to maintain pupils' interest.

A method which teachers thought was less than successful was the project work provided in S5, which they felt had unclear aims and which pupils found difficult to relate the topics to their own sexual health. The teachers' criticisms concerning the S5 project accurately reflected the sentiments of the pupils.

Suggestions for improving the programme

There were some relatively minor comments on amending or fine-tuning the programme. One teacher stressed that some practical exercises such as the modelling of body parts with fruit took too much time. The teachers mentioned that the S5 project work would have to be rethought. One teacher said that topics which seemed to be limited in their usefulness were:

S2: Week 1 and Week 3 'What is perfect?

S3: Students focus on HIV to the detriment of other STDs

S4: Week 2 'Communication' and Week 5 'Services for young people'

These latter two aspects of the S4 programme were seen as having a generally low level of interest from pupils. It is interesting that teachers felt that services for young people appeared to be of relatively low interest to pupils given that S5 pupils in the group interviews wanted information on sources of advice.

Coping with pupils' questions

Teachers thought that pupils had generally enjoyed the programme and asked questions on the subject matter. They did not raise any issues about having to deal with a question outside the formal curriculum for that year group. This is somewhat strange given that pupils in P1 and P5 said that teachers could be elusive and that many of their questions went unanswered. Only one teacher said that some pupils in S2 and S5 had raised topics beyond the formal curriculum: S2 pupils wanted to talk about oral sex and masturbation; S5 pupils wanted to learn more about abortions. Although felt that they had coped with these kinds of questions, this contrasts with the S5 pupils' accounts of some teachers who would not or could not respond to such questions. One teacher reported feeling uncomfortable only when the pupils seemed to be attempting to embarrass her. Another said that he adopted a question and answer session where pupils could ask almost anything. This seemed popular because the pupils could focus on their own concerns.

What did teachers think about their training?

The training was still viewed as excellent by the teachers after completing the programme. and they proposed no major changes to their training. However, suggestions for minor amendments were made. These were: more of the same type of training as they had received, extra time available to cover the materials and more discussion about the programme approaches and materials (a dilemma similar to that faced by the pupils with their course work).

Another comment highlighted the issue that there should be training programme for new staff who joined the sexual health teachers as well as up-dates for staff who have been teaching the course.

Views on teaching sexual health in subsequent years

The consensus was that the teachers were looking forward to teaching on future sexual health programmes and had no serious concerns. The teachers thought that pupils had generally appreciated the programme which further promoted teachers enthusiasm. The aims and ethos of the programme were reason enough for some teachers to commit themselves to the programme. One person explained that

> *I feel this topic is very important for young people and this overcomes any personal worries about presenting the material.* Male PSE teacher

It was thought that the Health Board should maintain its strong supportive links with the school to facilitate future developments and to keep the programme up-to-date with new materials, approaches and to provide appropriate training. The teachers all agreed that the support of the Health Board was essential in getting the programme to its current status.

■ Conclusion on phase 3

The overwhelming majority of pupils said they were very satisfied with the programme. The programme content was seen by most as relevant and interesting. The S1 and S2 year groups were particularly enthusiastic about their programme. Many of their questions concerning puberty and physical development had been answered. This was reported as having reduced their anxiety and promoted their confidence.

Only the S5 year group, particularly the girls, was critical of the programme. These girls felt that the programme content had not reflected their main concern which they had expressed in the pre programme questionnaires and focus groups. They had hoped to explore pregnancy and related issues but were less than satisfied with the coverage of these topics in the course. Furthermore, they reported feeling inhibited from asking questions of teachers and discussing these topics. The projects used in the fifth year were also criticised by S5 girls and to a lesser extent by S5 boys. The main conclusion in this respect was that these pupils were unaware of, or unable to see, the relevance of the project tasks to their own sexual health needs. Some also felt dissatisfied with the perceived lack of control they had over the way in which they addressed the project task.

The majority of the pupils were satisfied with the way the programme was taught by teachers and that the teaching had been better than they had expected. Again it was only the small group of S5 girls who were more critical of the teaching. They felt that because they could not be completely frank in their discussions with teachers, discussion of salient issues was 'stymied'.

While the majority of pupils were happy with the teaching they felt that it could have been improved further by having more time available for discussion. Often there was just enough time to cover interesting topics during a lesson but little time to explore the emerging issues. Most pupils said that they would welcome fewer self-completion worksheets in the programme

Overall, teachers thought the programme had worked well and they were still satisfied with the content and approach. Their involvement with the previous sexual health programme and the training and quality of programme materials for this programme had helped them to provide the curriculum to their satisfaction. Training was strongly praised but, similar to comments made before the programme, teachers wanted more training and provided earlier. Another suggestion was that mechanisms should be built into the programme to ensure that staff new to the programme receive training and existing staff receive up-dates to their skills.

The teachers felt that most pupils were very eager to learn and this had been another reason for the programme working well. Teachers noted that the programme had some difficulty engaging the interest and meeting the needs of some S5 pupils. The teachers commented that communication between teachers and S5 pupils concerning sexual health education did face some hurdles because some of these pupils were reticent about raising certain questions. The teachers speculated that for some programme content aimed at S5, perhaps external health workers could teach occasional sessions. However,

teachers seemed to generally confident that they could discuss many of the topics but pupils' perceptions possibly led to assumptions being made about what they could discuss with teachers.

Teachers were aware that pupils appreciated brainstorming and discussion most from the teaching approaches. The teachers were also aware, like the pupils, that lesson time constraints meant that there was not enough time available to discuss the topics to everyone's satisfaction. The only part of the curriculum that teachers felt had not worked particularly well had been the project work for S5 as some pupils expressed frustration and dissatisfaction with this because they could not see the relevance of the project topic.

Teachers were looking forward to teaching future sexual health programmes and had no serious concerns. The enthusiasm shown by most pupils for the programme further encouraged teachers. The future of sexual health education in the school should, the teachers believed, maintain close links with the Health Board to ensure quality training and advice on materials and other related matters.

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Appendices

1–3	**Summary of the three phases of the sexual health programme and corresponding evaluation and findings**
1.1	Summary of programme
1.2	Summary of programme cont.
2	Summary of evaluation approach
3	Summary of evaluation findings

Appendix 1-3:Summary of the three phases of the sxual health programme and corresponding evaluation and findings

1.1 Summary of programme

	Year 1	Year 2	Year 3
Programme aims	To 'raise awareness of the meaning of full-sexual well-being, encourage informed choice, and discourage unplanned pregnancy'		
Programme approach	School-based sexual health course taught to S1, S2 & S3 in single sex groups as part of PSE curriculum. Experiential learning approach moving between whole-class, small-group and individual work.	School-based sexual health course taught to S1-S6, mainly single sex groups as part of PSE curriculum. Experiential learning approach moving between whole-class, small-group and individual work..	School-based sexual health course taught to S1-S5, mainly in single sex groups as part of PSE curriculum. Experiential learning approach moving between whole-class, small-group and individual work..
	The overall programme approach is grounded in a belief that pupils should explore their own lives in regard to sexuality and sexual health. This experiential approach emphasises pupils' ownership of the issue and challenges misconceptions and myths with factual information. Pupils are encouraged to process their own decisions concerning sexual activity. Programme aims to encourage peer-support within classes to counter sexual pressure and embarrassment over body changes.		
Teacher's role	Assistant head teacher and all involved in the teaching of the PSE curriculum negotiated content with GGHB but did not teach. This was the initial stage of the model of establishing a sexual health programme with the health promotion staff	PSE teachers led two of the four sessions. Health workers from GGHB taught the other two sessions. This can be seen as a transition year with the duel aim of introducing teacher delivered sexual health education to pupils and, at the same time, provide experience for teachers.	Teachers deliver the total programme. They have access to advice provided by health promotion staff at GGHB
Duration	10 weeks, 1 lesson per week	4 weeks, 1 lesson per week	5 weeks, 1 lesson per week

1.2 Summary of programme Cont.

	Year 1	Year 2	Year 3
Content taught	Negotiation between GGHB and school identified content seen as appropriate and relevant for pupils. Content varied depending on year group being taught. Topics included: S1: Physical changes and puberty, Understanding how the body works, Feelings and relationships, Body image, peer pressure S2: Puberty, Understanding how the body works, Feelings and relationships, Sexuality, Assertiveness, Body image S3: Physical changes, Introduction to contraception, Sexually transmitted diseases, Basic health information/protecting your health, Self-awareness and assertiveness, Decision-making and critical thinking, Peer pressure	As for Year 1 but amended on the basis of experience and evaluation. Topics included: S1: Talking about sex, Puberty, Menstruation, Young peoples' opinions on sexual health S2: Where do we learn about relationships? Being a boy and being a girl, Media images, Legal issues and sex S3: Language game, Contraception, HIV & STDs, Safer sex, Making decisions S4: Pregnancy, Assertiveness, Negotiating in a relationship. Working out what help you need S5: Introduction, Video and discussion, Language and our bodies, Safer sex and sexual choices, contraception and pregnancy. S6 these pupils were integrated with S5	Content amended slightly on the basis of experience, evaluation. Topics included: S1: Talking about sex, Puberty and the body, Sexual body parts, Menstruation, Young peoples' opinions on sex S2: Where do we learn about relationships? Being a boy and being a girl, What is perfect?(Media images etc.), Everyone is different, Legal issues and sex S3: Language game, Contraception, HIV & STDs, Safer sex, Making decisions S4: Pregnancy, Communication, Power in relationships, Pressure Lines (resisting unwanted pressure regarding sex), Getting the help you need S5: Project based work geared to enabling students to examine in detail sexual health issues that affect them.
teaching approach	Content delivered by GGHB health workers only and utilised varied methods including discussion groups, self-completion and reading material, some role-play and quizzes. Highly interactive and responsive Single sex classes	Content delivered by GGHB health workers and PSE teachers. Varied methods including discussion groups, self-completion and reading material, some role-play and quizzes. Mainly single sex classes but one session, a play, was mixed sex.	Content delivered by PSE teachers only. Methods including video, some discussion, self-completion and reading material, and quizzes. No role play but S5 work involved a project. Mainly single sex classes but one session, a discussion, was mixed sex.

2. Summary of evaluation approach

	Year 1	Year 2	Year 3
Evaluation approach	The perspectives of pupils, health workers and teachers were gathered before and after the programme using group interviews with the pupils also completing a semi-structured folder. All PSE teachers (9) and those health workers (3) teaching the programme were interviewed. 3 classes randomly selected from S1, S2 and S3 PSE classes were interviewed in single sex groups (total 186 pre and 173 post).	Two aspects of evaluation: 1- Reviewed the impact of the first (10 week) programme. This involved 10 in-depth interviews with pupils (5 girls & 5 boys) randomly selected from S4. Retrospective questions were also built into the questionnaire which was used to evaluate Phase 2 of the programme. 2- Focused on the effectiveness of the second year of the programme. One PSE class in each year (S1-S6) was surveyed before and after their programme (89 pupils pre prog and 99 post prog). 2 S1 classes and 2 S5 classes were interviewed in groups to gather illuminative information about pupils' sexual health needs and perceptions of the programme. These year groups were selected to give an indication of pupils needs at the start and end of secondary school life. All 9 PSE and guidance teachers involved in teaching the programme were interviewed in groups as were the health workers. This was done before and after the programme.	This evaluation focused on participants' views on the effectiveness of the third year of the programme. The evaluation approach used for Phase 2 was duplicated. One PSE class in each year (S1-S5) was surveyed before and after their programme (130 pupils pre prog and 99 post prog). Group interviews with 2 S1 classes and 2 S5 classes were used to gather illuminative information about pupils' sexual health needs and perceptions of the programme. Before and after the programme, All PSE and guidance teachers involved in teaching the programme were interviewed as groups. The health promotion workers who had trained and advised the school were also interviewed.

3. Summary of evaluation findings

	Year 1	Year 2	Year 3
Evaluation findings	***Pupils' overall satisfaction*** Pupils were very satisfied with the programme and saw the programme as meeting their needs for accurate information in a supportive context. Pupils felt their knowledge and ability to make sexual health decisions had been enhanced. ***Pupils perception of the teaching approach*** Pupils were very satisfied with the health workers who taught the programme. As health workers were seen as 'supportive strangers' who had relevant knowledge and expertise pupils felt that they could discuss topics openly and so have their questions answered. Pupils also appreciated the diversity of teaching methods which made the content stimulating and assisted learning ***Teachers' views*** Teachers were willing to be involved in future sexual health education programmes but were ambivalent about their roles and expertise in this field. Teachers praised the design and delivery of the programme by health workers. The issue of deciding what content should be taught to which age groups emerged as pupils in S3 claimed to want information normally taught to S3.	***Pupils' overall satisfaction*** The pupils were found to be very satisfied with the programme with almost all those surveyed claiming they would be able to use what they had learned. However, those pupils who had experienced the first collaborative sexual health programme, taught solely by health workers, thought that the revised programme compared less favourably because the shorter duration meant topics could not be discussed at length. ***Pupils perception of the teaching approach*** Pupils were more accepting of teachers' involvement in the delivery of the programme. Before the programme pupils were against teacher involvement. However, many pupils still felt that there were limits to what they could discuss with teachers. This was mainly because pupils expected teachers to be judgmental and disciplinarian. The teachers, on the other hand, were restricted by their anxiety of parental reactions to their teaching style. ***Teachers' views*** Teachers' experience of teaching the content, along with their training, had boosted their confidence in delivering this type of programme. The findings highlighted the need for more time to collaboratively plan such programmes and train staff. The potential stress and difficulty of having a limited number of health workers work across a number of schools also emerged. Also, perceptions could vary about between teachers and health workers on what constituted a successful sexual health lesson.	***Pupils' overall satisfaction*** Pupils were generally satisfied with the content and teaching of this programme which was taught solely by PSE teachers. The exception to this were S4 and S5 pupils, particularly the girls. These pupils thought that the content did not fully reflect their needs and that discussion of relevant topics was limited. They identified problems with their own willingness to talk to a teacher about certain sexual health topics such as the risks and consequences associated with getting pregnant. ***Pupils perception of the teaching approach*** S5 pupils felt that difficulties in discussions between themselves and teachers was further compounded by some teachers' apparent unease with in-depth discussion of certain topics. Some of the older pupils (S4 & S5) still felt that teachers, by their very role, had to have a judgmental role. This further hindered open discussion. ***Teachers' views*** The teachers felt the programme had worked well in meeting the needs of most pupils. However, they were aware of the difficulty in meeting the S4-5 pupils' needs with a teacher delivered programme. This issue would require some thought on how best to progress. Teachers were also aware that the project work used with S5 had been less than successful and would revise this aspect of the programme.

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